

Health Seeking Behavior, Willingness and Ability to Pay for Selected Health Services in Urban Family Health Partnership (UFHP) Areas of Bangladesh

Report based on the field survey carried out during October-December 1999

FINAL REPORT

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Executive Summary

- 1. The study has been conducted to understand health-seeking behavior, willingness and ability to pay for health services of the people living in the catchment area of the UFHP facilities. The purpose of this study is to help the policy makers in deciding the level of user charges for selected ESP services, and to describe the possible impact of increasing user charges on utilization. The study also examined the role of community level workers in improving the knowledge and utilization of health care services and about illnesses.**
- 2. The study was conducted in areas served by 10 different UFHP funded NGOs providing ESP services. Households were selected from the catchment area of the static and satellite clinics of selected UFHP NGOs for the survey. These NGOs are classified in three different categories: A, B, C. Category A clinics are located in the metropolitan area, B and C in the municipal areas and small cities respectively. Listing of households was carried out within one-mile radius from the selected clinics. About 300 households were entered in the census list for each static/satellite clinic for the survey. These households were used as the sampling frame for the study. Four satellite sites were selected for each static clinic, hence the survey was carried out in the catchment area of 40 satellite sites, and ten static sites. The census collected data from about 15,000 households residing in the catchment areas of 50 sites. Information on basic household characteristics was collected to identify the eligible households for in-depth household survey.**
- 3. From the 300 households selected in each clinic area (static and satellite), 80 households were randomly drawn by categorizing them into different criteria/conditions for selection. The conditions were: currently pregnant women, and women who delivered recently, currently married women of reproductive age group and children of less than five years of age. The target was to interview at least 60 households from the 80 households. The total number of households surveyed in each clinic (the main static clinics and four satellite clinics) area were 300. For the ten-clinic area, 3000 households were interviewed for the in-depth survey on health seeking behavior, pattern and utilization of health facilities and willingness to pay for medical care services.**
- 4. Currently married women of reproductive age group were interviewed for the in-depth survey using six sets of household questionnaires. The “household information questionnaire” was used to collect information on demographic information, socio-economic status of the households, and on visit of field worker for social mobilization. The “knowledge questionnaire” collected information about women’s knowledge on: family planning methods, ANC, diarrhea and ARI of children, child immunization, signs of severity of diarrhea and ARI, positive and negative externalities of seeking various preventive and promotive health care services. Information on women’s knowledge about the providers in the locality, and prices they charge was also collected.**
- 5. The in-depth survey collected information on care seeking behavior for selected ESP services: child immunization, family planning services, and general illness. Information on last source used for these services, the amount of money spent, ability to pay, willingness to pay additional amount of money for the services/care, and opinion about the quality of services and willingness to pay for the quality improvement was also collected.**
- 6. To crosscheck the household information on quality and willingness to pay, the study surveyed a number of clients who have used the UFHP facilities. A questionnaire on “facility survey” were used to collect information on quality of care, type of services**

provided, the cost recovery strategy and charges for services. Two of the 10 static facilities were selected for this survey.

7. Patient's observation and exit interviews were conducted in six of the 10 facilities. This was done to find out the procedure followed by the NGO clinics to process patients. For policy purposes, it is important to know at what point the clients are informed about charges, who provides the information, who collects the fees, and who assess the clients' ability to pay. The exit interviews collected information on reasons for using the facility, total waiting time, total travel time and expenditure, total expenditure at the facility, opinion about the level of users fees, willingness to pay an additional amount for the services with and without quality improvements. Information was collected for 177 clients through this exit interview.
8. About 80% of the households in the census are from the satellite clinic areas. This is due to higher weight assigned to satellite clinics. The population in the satellite clinic area has higher number of children per household than that in static clinic areas. The number of currently married women per household was about one for all areas. The number of women delivering over the last 12 months varied from 7 per 1000 households in urban category A to 12 per 1000 households in category C. About 17% the households used poor construction material in the catchment areas of static clinics. This ratio was found to be 50% in the areas of satellite clinics. Among the census households 55% indicated that the main cause in the household are involved in daily wage employment.
9. The average household size of the households selected for the in-depth survey was 5.3. The age distribution of the population of the sample households is biased towards lower age groups. About 21 % of the individual belong to the age group less than five years. The population in the age group 15-39 is also higher than the national average.
10. About 60% of the head of the households in the static clinic areas reported to have completed five years of education. This proportion was about 28% in the satellite clinic areas, where half of all household heads had no formal education.
11. The households living in the satellite clinic areas were much poorer than the households in static clinic areas. About 57% of households in satellite clinic areas belonged to less than Tk. 3000 monthly expenditure group. On the other hand, 27.8% of households in static clinic area and 5.7 % in satellite clinic areas belonged to more than Tk. 7,000 expenditure category.
12. For all women in the survey (3148 currently married women in the reproductive age group), 93.5% knew that pregnant women should go to a medical care provider even though they are not sick. Lack of knowledge about ANC was 2% in category A clinic and 12% in category C clinic.
13. About 30% of the women mentioned that a woman should have 3 to 5 ANC visits over the whole pregnancy period. About 25% thought that the number of visits should be once per month and 13% mentioned either less than three visits or more than 10 visits.
14. Most of the women (about 91%) in the survey were aware of the benefits of ANC. The benefits mentioned are ANC service helps to identify mothers' physical problems and

position of the baby. Poor women appear to be less aware about the benefits of ANC than the women from richer households.

15. About 92% of women reported that they know at least one ANC provider in the locality. About 80% of all women mentioned public facilities as one of the ANC providers. This proportion varies with the degree of urbanization of the area. In most urbanized area (Category A), only 62% of women mentioned public facility as a source but in the least urbanized part of the country (Category C), 91% of respondents mentioned public facilities.
16. In most urbanized area (category A), 62% of women mentioned UFHP clinic while in category C area only 29% mentioned it as a source. More than 45% of women from the expenditure category less than Tk.5,000 per month mentioned UFHP clinic as a source compared to less than 30% for households with expenditures exceeding Tk.5,000.
17. About 30% of women were aware of a facility where ANC was available free in their locality. About 46% women in “C” category knew where they could find free ANC services compared to 27% and 13% in categories “B” and “A” respectively. About a quarter of women could not mention whether the facilities in the locality charge money or not.
18. About 76% of women were aware of at least one ANC provider charging money. 50% of them mentioned UFHP clinic as one of the providers providing care against a fee. About 28% from the lowest expenditure category and 13% from the highest expenditure category lacked knowledge about a facility, which is charging fee for ANC.
19. The respondents in lowest expenditure group reported that the normal charge for ANC range from Tk.20 and 30, and those in the highest expenditure group reported that it range from Taka 54 and 90.
20. The average price of UFHP clinic ANC services was reported to be Tk.14. About 18% of women consider the UFHP price as ‘high’ and more than 60% thought that the price was ‘OK’. Proportion of women reporting UFHP prices as ‘high’ declines with improving economic status.
21. 63% of women who delivered within 12 months prior to the survey sought ANC while 50% of women pregnant at the time of survey used ANC services. The lower rate among currently pregnant group may be due to early stage of pregnancy for some women. Proportion of women seeking ANC was found to be highest in Category B urban areas compared to that in A or C.
22. Over the last two-year period, the public sector as a source of ANC has declined in category A and category B of urban areas. In category C, role of public sector in the provision of ANC has remained more or less static. A significant expansion in the use of UFHP clinics in category B has been observed. In all categories, a higher proportion of women reported using UFHP clinics and this expansion was mainly at the expense of public sector.
23. The modal reason for using the public providers/facilities was ‘free service and free drugs’. The second most important reason mentioned was the presence of ‘qualified provider’ in the facility. For the users of private sector providers, the most common reason mentioned was the presence of ‘qualified providers’ followed by ‘convenient hours’ of the facility. For UFHP clinics, the modal group was that the facility is located ‘near the house’.

24. About a third of all women seeking ANC reported an expenditure of Tk.26 or more per visit. A significant proportion of women obtained ANC free of charge (24%). The use of free ANC services was more common among the poor households. Only about 15% of women belonging to household expenditure category Tk.5001 and above sought free ANC.
25. The average cost per ANC visit varies from Tk.18.30 for the lowest economic status group to Tk.94 for the highest economic status group. On the average, the reported ANC visit cost was Tk.42. The average cost of ANC in private sector was reported at Tk.110 while the average costs at UFHP clinics and public facilities were only Tk.16 and Tk.17 respectively. Other NGOs charge about Tk.28 on the average according to the women using the facilities.
26. Among the lowest household expenditure group, 38% used the public facilities and another 34% used UFHP facilities. Only about 13% of the poorest group went to private providers for getting ANC. For the richest group, 56% went to private providers and another 21% went to public facilities. Utilization of ANC services from UFHP clinics shows a systematic downward trend with improving economic status.
27. The estimates of the logistic regression model show that the utilization of ANC is affected by household expenditure level (up to Tk.6,000), having primary level education, knowledge score of woman about ANC, knowledge about the presence of a health center that provides free ANC care. The price charged by the clinics for ANC care was not statistically significant in the model.
28. About a fifth of all ANC users thought that the price they paid was too high and two-thirds considered the price as 'just right'
29. About 60% of women from poor households reported their willingness to pay (WTP) some additional money (over what has been paid) for the services. This proportion tends to increase with household income excepting the expenditure category Tk.5,001-7000. For public facilities the proportion was 66% and for UFHP clinics, it was 60%. In category C urban areas, 65% of women said that they will pay more money for ANC while the proportions were 62% and 58% for category A and B areas respectively.
30. The median value of willingness to pay was found to be about Tk.40 for public sector, Tk.150 for the private sector and Tk.40 for NGOs, when we consider only those women who paid for their last ANC visit. If the last visit was free, the willingness to pay amounts was significantly lower, Tk.13 for public sector, Tk.27 for private and Tk.17 for NGO facilities.
31. Among the women who paid some money during the last ANC visit at UFHP, the average willingness to pay varies from Tk.22 for the lowest economic category to Tk.41 for the richest group. There is a clear increasing trend in willingness numbers with improving economic status.
32. Estimates of regression models suggest that knowledge about ANC service affect the WTP significantly in all areas. A 10% increase in knowledge index from the mean value will increase the willingness to pay for ANC services by about Tk.1.25. Access to free care reduces WTP significantly, it is about Tk.14 lower than the others who obtained care at a fee. The effect of access to free care was strong in urban area A and B but the variable shows no impact in urban area C. Education of woman seeking care is another significant variable in affecting WTP. Those who have more than five years of education are willing to pay Tk.50 more than others.

33. Economic status has no impact on WTP for ANC services except in Urban C areas where it has been found that an increase in the household economic status or expenditure levels by 10% will increase the WTP by about Tk. 1.81.
34. 98% of women knew about the need for immunizing children by age 12 months and they also knew the sources of such services. The most common source mentioned was the 'public facilities' followed by the UFHP clinics. Other NGOs were also mentioned by about a quarter of all women. Private facilities were mentioned by only 5% of respondents.
35. Ninety nine percent of women in the survey knew about the benefits of childhood immunization. More than 73% of the respondents mentioned that immunization prevents diseases of children.
36. 31% of the children in the survey were not immunized. Almost perfect knowledge about immunization did not translate into actually obtaining immunization. In terms of proportion of children immunized, urban category B was the best followed by urban category A and C.
37. Out of the total number of immunized in the last three months, 48% obtained their last immunization from the public facility and 32% obtained that from the UFHP clinics. Only 5% reported obtaining immunization from private facilities. Other NGOs provided immunization to 15% of children.
38. The modal responses for reasons for choosing the facility: close to the house for public sector, other NGOs and UFHP, free service or free drugs for public sector and other NGOs, convenient hours for private facilities. For UFHP clinics, close to the house is the predominant reason (52% mentioning the reason).
39. About 50% of all women obtaining immunization for children got the service free of cost and another 44% received the service by paying less than Taka 10. In public facilities about 73% of immunizations were obtained free. In UFHP clinics, 37% received free immunization. The proportion of children getting free immunization appears to be independent of expenditure levels.
40. The average charge for one immunization visit was Tk.3.73. Cost of immunization varies quite significantly by source of care. The average cost of immunization in the public sector is Tk.1.42 and in other NGOs, it was Tk.7.63. The UFHP clinics charge about Tk.5.00 for immunization on the average. The average cost of immunization in the private sector is also quite low, lower than what 'other NGO's were charging.
41. Although the immunization charges are low, 17% of mothers felt that the charge was too high. Almost 70% of the mothers were of opinion that the charges they have paid were 'alright'. Excepting the richest household group, about 20% mothers from all other groups felt that the prices were too high. About a quarter of all mothers from expenditure categories Tk.5,000 and above reported that the price they paid were too low. About a fifth of UFHP users thought that the UFHP price for immunization was too high and another one fifth thought that the UFHP price is too low.
42. About 56 % of the mothers who have paid some money for immunization during the last visit were willing to pay more money. The proportion willing to pay more money remains at

around 50 to 60% for expenditure categories less than Tk.7,000, and 84% in the next higher expenditure group. The proportion of households willing to pay more was about 65% for both public and private providers and about 50% for UFHP and other NGOs. Proportion willing to pay more for immunization was lowest in category A areas and highest in the category B areas.

43. The average WTP for immunization were found to be Tk.11, Tk.15 and Tk.14 for public, private and NGO providers for those who paid some money in the last visit. The average willingness tends to increase with economic status of households. It remains about Tk.7 to 8 for the mothers who did not pay anything during the last visit.
44. The estimates of multivariate analysis shows that household expenditure levels increase willingness to pay by Tk.0.0007 for each Taka increase in expenditure. Five or more years of education of women increases the WTP for immunization by Tk.1.50, knowledge about the presence of a free facility reduce WTP by Tk.4.70, etc.
45. About 48% of women could identify three major symptoms of ARI (unprompted) in the survey. In urban location A, a higher proportion of women could identify the symptoms (56%) while in urban category B about 42% could mention the three major symptoms.
46. More than 95% of women knew at least one provider for ARI related care. Knowledge about source of care was slightly higher in urban category C than in categories A and B. Three quarters of all women mentioned private facilities as a source while 47% mentioned public facilities as a source. The UFHP clinic as a source of care for ARI was mentioned by only 14% of women. The average number of sources mentioned per woman in the survey was about 1.4. Only 21% of women knew at least one provider who supply service free of cost. The knowledge about the presence of free provider is much higher in urban category C than in other two urban categories. 24% in the lowest expenditure category knew a free care provider but it was found to be about 18% for all other expenditure categories.
47. Although a high percent of women did not know a facility where ARI treatment was provided free of charge, about 90% knew a facility where ARI treatment is provided for a fee. This type of knowledge about market situation is slightly lower in category C urban areas.
48. On the idea of the respondent's market price for ARI treatment, the average of maximum reported prices charged for ARI treatment was Taka 64.76 while the average of minimum was Tk.40.64. The average prices show an increasing trend with expenditure levels of the households. The average price mentioned for UFHP was less than Tk.15, much lower than the average of the minimum prices in the locality. About 17% of women who knew about UFHP clinics mentioned that the price was too high and 14% thought that the price at UFHP clinics was low.
49. About 97% of women could identify a place where treatment for diarrhoea was available. Most of the women mentioned the public and private facilities as sources of care. Only 6% of women reported UFHP clinic as a possible source of care, indicating that they do not consider UFHP clinic as a source of curative care services.
50. About 35% of women reported that they were aware of facilities where treatment for diarrhoea was available free of charge. In urban category C, almost 50% mentioned that

they knew a free facility for treating diarrhea but the proportion was less than 30% for urban categories A and B.

51. 78% of women were aware of at least one provider in the locality who delivers treatment for diarrhea by charging money. This proportion was lowest in urban category C (68%) and highest in urban category B (90%). The UFHP clinics were also mentioned as a source of care in exchange for money by only 8.5% of respondents. Less than 8% of women in the lowest expenditure category mentioned UFHP clinics as an option but the proportion was about 13% for the highest expenditure group.
52. The number of illnesses per household over the two-week period was 0.75. The reported prevalence rate of illness among the survey individuals was about 141 per thousand.
53. 50% of all illness cases did not seek medical attention. The proportion not seeking care varied from about 45% in urban category A to 54% in urban category C. Among the users of medical care, more than 80% sought care from private providers and another 12% obtained care from public facilities. Only about 3% of illness cases obtained care from the UFHP clinics in the location, which is consistent with the response obtained from the women about their knowledge of sources of care for curative services.
54. The average cost of care was highest in urban category B followed by urban category A. The average cost in public facilities was also quite high. This may indicate that the severity-mix of the illnesses seeking care from public facilities may be higher than the severity-mix in other sources. The UFHP clinics show relatively low cost and the severity of cases showing up in UFHP clinics, by definition, should be very low.
55. No relationship between willingness to pay and educational status of women, knowledge about illnesses, were found in multivariate analysis. Only variable that turns out to be statistically important in explaining WTP is the expenditure level of households. Increase in the household expenditure by Tk.100 per month will increase the willingness to pay for curative care by about Tk.5.
56. About 97% of the women knew the places to get family planning methods. 67% of the respondent mentioned private providers as a source and 60% mentioned public facilities as a source. About 46% of women also mentioned UFHP clinics as a source. Knowledge about UFHP clinics as a source of family planning services was highest in urban area A. About 1.9 sources per woman were noted. On the average this is the highest number of sources mentioned among all the different types of services considered in this study.
57. Women from higher economic status mentioned private sector as a source (more than 70% compared to 63% for the lowest expenditure category).
58. Only about one third knew about a free provider of family planning services in their area. About a quarter did not know whether the providers in the locality were free or not. In the urban category A only about 10% reported knowing a free provider but in urban category C more than 50% knew a free provider of family planning services.
59. About 24% of women mentioned public sector facilities as a source. Private providers and facilities were mentioned by about 38% of women and 29% mentioned UFHP clinics. Other NGOs and other providers constituted only a very small proportion of total, less than 10% of the current users. In category A area, 12% mentioned public sector as a source but in

category C about 36% mentioned public sector as a potential source. The UFHP clinic was mentioned as a source by 35% of women in A but by only 23% women in C.

60. Women selecting private sector as the source were basically pill users (96%) and UFHP clinic users were equally split between adoption of pill or condoms and injectables. For injectables, UFHP clinics were the principal suppliers accounting for 70% of total injectable users. For IUD/Norplant and sterilization, public sector is the predominant supplier.
61. The modal reason mentioned for selecting public facility was that the services were provided free of cost. The modal reasons for private, UFHP and other clinics were convenient time of operation, close to the house and convenient time of operation respectively. Privacy has been mentioned by 11% of responses for the reason for selecting private providers and by only 1.2% of the UFHP facility users. Cleanliness and lower waiting time was mentioned less than 3% of all respondents.
62. The average costs of family planning services vary quite significantly among all the sources of care. The average cost of family planning services in the public and private sectors were Taka 1.00 and 14.00 respectively. For other providers, the average price was about Taka 7.00. The average cost of a family planning visit was found to be about Tk.8.00. A higher proportion of women from the lowest household expenditure group obtained free service and supplies (27%) than that in the highest expenditure group (16%). Only 2.4% of users of UFHP clinics mentioned that they obtained family planning services free of cost
63. About a fifth of all women mentioned that the price they have paid for family planning was too high. About 70% mentioned that the price they have paid is all right. About 12% women using UFHP clinics and 16% using public facilities mentioned that the prices they have paid were too low.
64. About 52% of women mentioned that they would pay more than what they have already paid to obtain the family planning services. The willingness to pay more increases with the economic status of the household.
65. The average willingness to pay for family planning services in the public sector was Tk.12 for those who paid a price and Tk.9.25 for those who did not pay anything for getting family planning services or supplies. The average willingness to pay for the private sector was higher than any other sources, at about Taka 19. The average willingness number for NGO service providers was about Taka 13, irrespective of whether the women paid for the service or not.
66. Multivariate analysis showed that knowledge about a free provider or obtaining service for free in the past do not affect the willingness to pay for family planning services. Education of woman (whether the woman has five years of education or not) significantly affects the willingness to pay in all urban regions.
67. The Community Health Workers (CHWs) visited about 25% of all households in the survey. CHW visits are not specially targeted towards the households with low income or low educational status of women. The CHW visits are not also related to knowledge and utilization of specific health care services like immunization and ANC services. Women's knowledge about immunization and ANC were not higher than the average if the household was visited by a CHW.

- 68. CHWs can potentially play an important role in increasing the demand for health care service and the willingness to pay for various health interventions. Knowledge about health care services turned out to be an important variable affecting the willingness to pay. Women from lower socio-economic groups have lower level of knowledge and if the CHW activities are targeted towards them, it will help to increase the utilization of services as well as the willingness to pay for the services.**
- 69. The exit interview information indicates that the average waiting time was highest for obtaining immunization services (27.66 min.). Average travel cost was minimum for maternal service.**
- 70. The other NGO in the study areas were found to be providing ESP services. They were found to have field workers to providing doorstep services. The UFHP clinics were found to be more equipped with IEC materials**
- 71. Using a definition of a basic health service package (which included ANC services, immunization of children, family planning services, child hood illness and adult illness), cost was estimated for each of the households depending upon the demographic characteristics of the household. Using the median and mode values of the reported price paid, total cost of the service package was estimated and then compared with the household expenditure level to determine the proportion of households who should be able to pay. If the prices for the services were set at the modal value, only 3.7% of the households will not be able to pay. Using any other price levels the program managers can simulate the results to examine the impact of change in price of services.**

Health Seeking Behavior, Willingness and Ability to Pay for Selected Health Services in Urban Family Health Partnership (UFHP) Areas of Bangladesh

1. Introduction

The Government of Bangladesh (GOB) adopted a comprehensive health and population project during the fourth five-year plan (1990-95) which recommended decentralized but 'functionally integrated family planning and health services'. By the end of 1995, the country saw significant progress in rural health infrastructure development, contraceptive prevalence rates, development of private hospitals, improvements in safe water supply and decline in infant mortality rates. Despite the improvements in general health status of the population, a number of shortcomings of the system also became apparent by the end of 1995. The quality of service provided through the public sector remained very poor which affected its utilization rate. Vertical segmentation of family planning and health services led to inefficient use of resources and inadequate provision of primary or essential health services adversely affected the health of the disadvantaged groups, especially the poor and women.

A number of research findings also questioned the efficacy and effectiveness of existing health and family planning delivery structure. For example, it was observed that the family planning program of the country showed significant progress and most of the ever-married women were fully aware of the benefits of family planning services. In this situation, high-cost doorstep delivery system is not needed. But on the other hand people have little confidence in the static health care facilities. The presence of unofficial payments, frequent absence of health care providers from duty stations, poor quality of care are the principal reasons for the low confidence in the system. Household surveys also indicated that people in both rural and urban communities would like to see one-stop service centers, where all types of health care services, including family planning and immunization, will be provided. Dissatisfaction with the public health care delivery system led to the development of Non-Government Organization (NGO) run and other privately organized health care facilities.

The current plan, Health and Population Sector Program (HPSP) 1998-2003, addresses some of these concerns of the health system. The HPSP officially integrates health and population activities at all levels to reduce costs, improve the referral system and quality of care. The HPSP explicitly accepts the fact that resource availability in the public sector is too low to provide all types of medical and health care services to the population. Therefore, the limited resources available must be used in the most efficient manner and a package of health care services has been defined (Essential Service Package, ESP) to ensure that the available money is used in interventions with highest levels of potential health outcomes. The delivery of Essential Service Package (ESP) is one of the major initiatives of the Health Sector Reform being implemented by the Ministry of Health and Family Welfare, Government of Bangladesh. By the end of the fifth plan, the GOB intends to ensure universal access to essential health services of acceptable quality. The components of ESP are: Reproductive Health Care, Child Health Care, Communicable Disease Control, Limited Curative care, and Behavioral Change Communication.

The sector-wide approach is intended to improve the performance of the health sector and to enhance the efficiency in resource use. The ESP under the HPSP has been developed to cater to the needs of the most vulnerable groups in the society- women and children from the poor families. According to the current plans, the ESP will be implemented in a phased manner based on the resource availability and cost-effectiveness of the interventions. For efficient implementation of the reform strategy, it is extremely important to estimate the amount of resources needed for delivering this package of services. There are several estimates of financial resource requirement of ESP under the HPSP. It is estimated that the full ESP will cost about US\$ 13 per capita per year but the current health expenditure in Bangladesh is about US \$8.5 per capita per year (in modern allopathy medicine), implying a resource gap of US \$4.5. The government does not have enough resources at its disposal to bridge this gap. Therefore, the

implementation of ESP will require participation of various NGOs and private providers and generation of additional resources from alternative sources. Cost recovery strategies are being tried by the NGOs to generate additional resources. Planners are also considering user fees and other forms of cost recovery for resource mobilization and to reduce the misuse and wastage of resources.

The application of user fee as a cost-recovery strategy has been proposed both for the non-profit sectors and the public providers. User fees are not new in Bangladesh. Many private providers do charge fee for the services they provide. However, imposition of user fees should carefully consider the consequences of the prices, especially on access and utilization of basic primary care services. The pricing policy should try to enhance social wellbeing by examining various aspects of medical care delivery. The resource mobilization aspect is important if it can directly affect the supply of services. Pricing policy must also take into account the health seeking behavior of the population, the perceived quality of care received, the value people assign to the medical care services at the local level and the role of provider-consumer communication in household decision making. In a poor community, it is important to examine the feasibility and desirability of user fees or some form of cost-recovery very carefully by analyzing the effects of cost-recovery policies on utilization, health-seeking behavior.

Under the National Integrated Population and Health Program (NIPHP), the Urban Family Health Partnership (UFHP) funded various NGO-run health facilities to provide the ESP services to urban population of Bangladesh. Besides its efforts for the improvement in management and quality of service, the NIPHP emphasizes the sustainability of health care delivery activities. In order to attain sustainability, cost recovery through the introduction of user fees has been adopted. The current shift of the program focus on the delivery of an essential package of health and family planning services (ESP) requires a pricing strategy based on all the important components of the package. There are two distinct but inter-related aspects of pricing at the primary care facility level: first, the overall objective of pricing policy will guide the policy makers to choose the appropriate types of interventions and second, the levels at which the prices should be set. For example, if the principal objective of a pricing policy is to reduce wastage rather than resource mobilization, the prices may be set without considering the cost of production of the services. However, if cost-recovery is an important objective, the policy makers need to find out the cost of production of various components of ESP, the exemption policy to be followed for increasing social benefits, cost recovery targets, the possibility of cross subsidization, and health seeking behavior of the population in terms of the ESP services.

It was felt by the service delivery partners and the USAID that a pricing policy with specific guidelines and suggestions should be devised and made available to the NGOs delivering the ESP services to rationalize the use of health care resources allocated to the primary care facilities of the country. In order to address the issues on utilization of medical care services and willingness to pay, a working group was formed with the participation of USAID, UFHP, RSDP, and ORP/ICDDR,B. The working group identified a number of research issues related to health seeking behavior of the population, the definition of quality of care in the context of Bangladesh, and willingness and ability to pay for health care services.

On the provider side, it was felt that it is necessary to assess the unit cost of services and effects of quality changes on costs. Many of the NGOs provide the ESP services to the population but the cost of providing the services is not known. A rational pricing system needs to consider not only the willingness to pay of the consumers/customers but also the resource requirements in the delivery of the services. Therefore, pricing policy analysis should examine the willingness and ability to pay for the ESP components by the consumers and the cost of producing the ESP components at the local level. The costing exercise should also indicate the effect of quality improvements, management efficiency, changes in utilization, and personnel mix on the cost of production.

To clearly define the scope of this study for UFHP/JSI, the working group met with the Health Economics Program (HEP) of ICDDR,B to discuss the methodology to be followed, types of information to be collected, and the analysis plan. The HEP developed a study proposal taking into account the information needs identified and other related ideas and suggestions discussed in the meetings during the preparation phase. The revised final proposal was submitted to the UFHP/JSI office in August, 1999 and a contract was

signed between UFHP/JSI and ICDDR,B on 15 August 1999 to undertake a study for examining the willingness and ability to pay of the population for various components of ESP.

2. UFHP HEALTH CARE DELIVERY SYSTEM

The National Integrated Population and Health Program (NIPHP) of USAID started its activities on 1 July, 1997. The program consists of nine partners, each responsible for a specific aspect of health and medical care delivery. Two of the partners – Rural Service Delivery Partnership (RSDP) and Urban Family Health Partnership (UFHP) – deliver a set of primary health care services, the Essential Service Package (ESP), through clinics operated by NGOs.

The ESP of NIPHP consists of the following types of medical care services: family planning (clinical and non-clinical methods), maternal health care (ANC, PNC and iron supplementation, TT, safe delivery, EOC, Post-partum complication, and post-partum contraception), management of RTI/STDs, HIV/AIDS, child health (that include EPI, Vit. A, CDD, ARI, IMCI) and selected communicable and vector borne diseases (tuberculosis, malaria) and limited curative health care. The HPSP package includes a number of additional services not provided through the NIPHP clinics. For example, the HPSP defined package also includes treatment and prevention of communicable diseases like leprosy, kala-azar, filaria, intestinal parasite, and MR in the reproductive health.

Compared to the previous USAID-funded program in the health sector, the NIPHP introduced the following two major changes:

- Provision of a broader range of health and family planning services;
- Switch from doorstep service delivery by field workers to clinical delivery by trained technical staff.

The UFHP delivery model has two tiers: satellite clinics and static clinics. The UFHP, for the delivery of health and family planning services, has divided the country into 25 urban clusters and contracted 24 NGOs to provide ESP in these clusters. The UFHP categorizes the urban clusters into three groups: A, B and C. The categories of urban areas are defined by considering the size of the urban area, population density etc.

The UFHP tries to make high-quality ESP widely available to the urban population and has set a minimum standard and requirement for the delivery of quality services. Currently, the UFHP delivers health and family planning services in urban areas of Bangladesh through 121 static clinics run by 24 NGOs.

3. OBJECTIVES OF THE RESEARCH

Most of the UFHP NGOs charge user fees for the services they provide through the health centers. It is assumed by the UFHP that customers/potential customers will be willing to pay for the services when the quality improvements are realized. This research work was initiated to examine the willingness to pay of the population residing in the catchment area of the health centers. The NGOs contracted by UFHP have already adopted a user-fee-based service delivery system. Nevertheless, to improve efficiency in service delivery and to protect the poor, the UFHP is interested in determining a proper pricing policy and strategy that will be based on careful evaluation of costs of production, willingness and ability to pay of the clients. The delivery system is also interested to find out the possible effects of user charges on utilization of services and implications for access to care by the disadvantaged groups, the poor and women. The quality of care provided through the health centers is also important in determining the willingness to pay. If a specific level of quality care is ensured by UFHP, the willingness to pay indicates the amount of money the consumers or clients are willing to pay for the specified service quality.

Although all these questions are important for a comprehensive pricing policy, the UFHP decided to carry out the study in phases or stages through various research organizations. The Health Economics Programme of ICDDR,B was responsible for a number of specific areas of the research questions mentioned above. The definition of 'quality' from the client's point of view was examined by a separate research initiative. The cost of producing health care services in the UFHP facilities were conducted by another study of UFHP.

The HEP of ICDDR,B examined the following aspects of pricing policy through this research:

- a. To understand the health seeking behavior of the population in the catchment area of the health facilities
- b. To examine the willingness and ability to pay for the health services provided by the NGO clinics
- c. To suggest the level of user charges for each of the ESP services based on the willingness survey as well as actual price paid by household members.
- d. To examine the extend of “social mobilization” contacts in the catchment areas and the potential effects on knowledge about health and illnesses, willingness and ability to pay for the ESP services and its utilization.
- e. To understand the perception and knowledge of households about the benefits of the services provided by the NGO health facilities.
- f. To describe the possible impact of increasing user charges on utilization of various services.

4. METHODOLOGY OF THE STUDY

4.1 Survey Method

This study mainly concentrates on the survey of household in the area served by UFHP to collect information on household characteristics, households' health seeking behavior, knowledge about benefits and costs of preventive and curative care, willingness to pay for services.

Ideally, health care seeking behavior survey should have a number of discrete steps. These include: a qualitative survey to prepare a list of commonly occurring illnesses and conditions with local terminology; a key informant interview survey to list all the health care options available in the community; a survey of providers to understand the types of services provided, training and experience of health care personnel, quality of physical infrastructure, household survey to explore illness occurrences and utilization of services, and household survey to understand the willingness and ability to pay for different types of health care services.

Considering the constraint of time and other resources, the following survey methodology was adopted:

- i. Select urban health centers of UFHP for the survey
- ii. Select household for the survey from the catchment area of UFHP health centers and their satellites
- iii. Exit interview of selected clients using UFHP health center.

The primary objective of the study is to determine the willingness to pay for primary health care services, including family planning, of the population living close to the UFHP health centers, The presence of other health centers and other medical facilities may change the willingness to pay for services. Therefore, to come up with a pragmatic proposal on pricing levels and structure, the household survey should be carried out in the catchment area of UFHP clinics and the satellite. The selection of UFHP clinics for the survey should be based on the health care market structure in the area, degree of competitiveness, clinic type and utilization pattern. Therefore, the study explicitly designed an appropriate sampling mechanism for the selection of the clinics.

(a) Selection of the fixed and satellite clinics for the survey

The study was designed to select households from the catchment area of the UFHP static and satellite clinics. The first step in sampling was to select the UFHP clinics from different urban categories: A, B, and C. These categories are defined by the size of urban area or the degree of urbanization in which the clinic is located. Clinics in categories A are located in major cities, and clinics in category B and C are located in smaller cities. It is expected that UFHP will expand C categories of clinics in the future. UFHP suggested to select three from each and an extra one be selected from category C. So, from the list of all clinics under UFHP contract, four clinics from category C, and three each from A and B were selected randomly. The static clinics selected for the survey are listed in Table 1.

Table 1: List of the UFHP NGO Health Centers Selected by the Study

NO	CATEGORY	NGO NAME	CLINIC
01	A	NISHKRITI	Static Clinic # 4, 58 Kazi Nazrul Islam Road Firingi Bazar, Chittagong
02	A	PSKP	Static Clinic # 3, House 11, Road 11/2, Block-B Section-10, Mirpur, Dhaka

03	A	FPAB	Static Clinic # 1, 103 Central Block, Eidgah Road Khalishpur Housing State Khulna
04	B	CAMS	Static Clinic # 1, Pandit Para, Goakhola Road Chandpur
05	B	VFWA	Static Clinic # 1, Alipur Faridpur
06	B	UPGMS/B	Static Clinic # 1, Dinajpur Road, Namajghar Bogra
07	C	SSKS	Static Clinic # 3, Sabuj Bagh, Hospital Road, Habiganj
08	C	CWFD/M	Static Clinic # 2, Ajhore Road, Netrokona
09	C	MALANCHA	Static Clinic # 3, Hospital Road, Sharisha Bari
10	C	TILOTTOMA	Static Clinic # 4, Sharishabari, Nawabganj

Once the static clinics were selected, all satellite clinics associated with each of the static clinics were listed. Four satellite clinics were randomly selected from the list of all satellites under a static clinic.

Table 2 lists all the satellite clinics selected for survey by the static clinic of the satellites.

Table 2: List of Satellite clinics Selected for Survey by Static clinics Selected

NO	CATEGORY	NGO NAME	CLINIC	SATELLITE SITES
01	A	NISHKRITI	Static Clinic # 4, 58 Kazi Nazrul Islam Road Firingi Bazar, Chittagong	Satellite sites Hazi colony Station collony Patharghata Yakubnagar
02	A	PSKP	Static Clinic # 3, House 11, Road 11/2, Block-B Section-10, Mirpur, Dhaka	Satellite sites Mirpur-13 Bashantake Mirpur Mirpur
03	A	FPAB	Static Clinic # 1, 103 Central Block, Eidgah Road Khalishpur Housing State Khulna	Satellite sites Pura Mosjed East Bosra Port Collony Gobor Chaka
04	B	CAMS	Static Clinic # 1, Pandit Para, Goakhola Road Chandpur	Satellite sites Tila Bari Shabdar Khan Bari Nataiganj Nazirpara
05	B	VFWA	Static Clinic # 1, Alipur Faridpur	Satellite sites East Khabashpur Komlapur Vatilokhipur Greholokhniapur
06	B	UPGMS/B	Static Clinic # 1, Dinajpur Road, Namajghar Bogra	Satellite sites Chalopara Catnarpara Phool para Brinda ban bari
07	C	SSKS	Static Clinic # 3, Sabuj Bagh, Hospital Road, Habiganj	Satellite sites Umodnagar Kaligachhatala Nazirabad Anantapur
08	C	CWFD/M	Static Clinic # 2, Ajhore Road, Netrokona	Satellite sites Purbo Malini Shatpai Rishi para Pukuria
09	C	MALANCHA	Static Clinic # 3, Hospital Road, Sharisha Bari	Satellite sites Kona Bari Dhanata Kamrabad Bhurar bari
10	C	TILOTTOMA	Static Clinic # 4, Sharishabari, Nawabganj	Satellite sites Azaipur Shiala collony Chandlai P.T.I Master Para

(b) Selecting households from the catchment area of UFHP clinics

The principal purpose of the study is to examine the willingness and ability to pay for ESP services by the population residing in the catchment area of the UFHP clinics. The catchment area of a clinic is not well defined and there is no administratively defined catchment area for the NGO clinics. To examine the research questions of this study, the survey considered the static clinics and the satellite clinics as the center of the respective catchment areas. Starting from the center, listing of households was carried out within about one mile radius. The circular movement away from the center was stopped at a lower distance than one mile if about 300 households were entered in the census list.

A simple structured questionnaire (the census questionnaire, Annex B) was used to list these households. Information on basic household characteristics was collected to identify the eligible households for in-depth household survey.

A team of three members conducted the census in each clinic/satellite clinic sites. The team consisted of two female interviewers and a male team leader. The female interviewers visited all the households and actually conducted the interview. The census-based list of households was used as the sampling frame for the study.

The census included 300 households from each static and satellite clinic sites. Since four satellite site were selected for each static clinic, the survey was carried out in the catchment area of 40 satellite sites. Therefore, the census survey collected data from about 15,000 households residing in the catchment area of 50 sites (10 static and 40 satellite sites).

In Bangladesh, one of the most important variables affecting the utilization of a health center is the distance of the health center from home. A study carried out by the Centre for Policy Dialogue (Ahmed 1995) found that more than 80% of the clients of primary health care facilities come from within two kilometers radius. To understand the health care seeking behavior, pattern and utilization of health facilities and willingness to pay for medical care services, the sample should be drawn from households living close to the UFHP clinics.

Therefore, a random selection of households from a pre-defined catchment area will not be appropriate, especially when distance plays such an important role in determining utilization. If all households living within a mile radius from the health center are included in the sampling frame, the study should be able to identify factors other than the distance affecting the utilization of the target facilities. Besides, the main purpose of the study is to understand the health seeking behavior, willingness and ability to pay rather than the rate of utilization of an arbitrarily defined catchment area. Therefore, starting from a pre-defined catchment area will not be appropriate for the purpose of this study.

From the 300 households selected in the census around each clinic area (static and satellite), 80 households were randomly drawn by categorizing them into different groups using a set of criteria/conditions. The conditions were: currently married women of reproductive age group, children of less than five years of age, currently pregnant women, and women who delivered recently. The first condition used in the selection process was the presence of a woman in the household who was pregnant or delivered in the last one year. The second criterion for selection was the presence of at least one reproductive age group woman and a child of less than five years.

If more than 80 households satisfied the criteria, households having lower socio-economic status were used as an additional selection criteria to select the first 80 households. That is household falling in the rich socio-economic status was excluded in this situation. The target was to interview at least 60 households from the 80 households selected. The over selection at the first stage allowed the research study to interview the minimum desired sample of 60 even if a number of households refuse to be interviewed or non-availability of the household for interview. The total

number of households surveyed in each study site (the main static clinics and four satellite clinics) area was 300 (5x60). For all the ten clinic areas under the survey, 3000 households were interviewed for the in-depth survey.

(c) Questionnaire development and training of enumerators

The household census questionnaire collected very basic information about the households living in the catchment areas. The data collected during the census included: information on the location of the household, name of the head of household, presence of at least one reproductive age group woman in the household, presence of at least one under-five child in the household, presence of a pregnant women in the household, presence of a woman who delivered a baby during the preceding 12 months, etc. The census questionnaire also collected information about the quality of housing, and whether the main earner of the household worked as a day laborer in the past. Both of these data types were included to understand the socio-economic status of the households.

The in-depth household interviews were carried out to collect information on common illness occurrences and health service utilization in the community during the last two weeks prior to the visit. Recall period of two-weeks may be too short for certain types of services provided through the ESP. For example, antenatal care (ANC) services are used by about 60% of all women giving birth during the year. The Crude Birth Rate (CBR) in Bangladesh is about 25 per thousand and therefore about 15 per thousand use ANC over their pregnancy. If the recall period of using ANC services is three months, we should get only four users per thousand population. A recall period of one-year should increase the numbers to about 16 per thousand. Therefore, a random sample drawn from the household list will not generate enough cases of ANC and possibly other health services for statistical precision.

To ensure that a higher number of pregnancy cases and users of ANC services are observed, the selection of household for the survey was biased towards households with at least one woman in the reproductive age group and having a child of less than two year old. Most of the ESP services delivered by the NGOs are for women in their reproductive age group, children of age less than five years and pregnant women. Therefore, selecting the households satisfying the above three conditions should provide the relevant information on the use of ESP services in the country.

The survey used the following questionnaires for the study:

- (i) Household census form
- (ii) Questionnaire to understand household knowledge about the benefits and costs of preventive and curative care
- (iii) Questionnaire on antenatal care
- (iv) Questionnaire on child immunization
- (v) Questionnaire on family planning services
- (vi) Questionnaire on other illnesses.
- (vii) Questionnaire on patient observation & exit interview
- (viii) Questionnaire on facility survey

All the questionnaires, excepting the census form, were translated into Bangla for pre-testing. The draft questionnaires were pre-tested by HEP field investigators in two UFHP areas. The revised questionnaires were finalized by the HEP after discussions with Dr. Kanta Jamil of USAID and Mr. Noor Mohammed of UFHP.

The HEP organized the training of field researchers during October 4-12, 1999. Practical training on field survey was also organized in Shahzadpur and Shamoli areas of Dhaka. The household survey of UFHP started on October 16, 1999.

Once the households are selected, the in-depth household survey were carried out to understand the health seeking behavior of the population, especially the preventive services as well as maternal and child health related activities. The individuals selected as respondents for the in-depth survey were the mothers in the reproductive age group.

The household in-depth questionnaire (Part I at Annex B) was used to collect the following information: demographic information (age, sex, marital status of the members of the household, eligibility as respondent for the survey i.e. currently married women of the reproductive age group), information on socio-economic status (housing structure, ownership of land and household, household expenditure, household assets and their ownership), asset ownership, etc. The questionnaire also included a checklist to determine the number of respondents in a household acceptable for providing information on family planning, child immunization, ANC care and illness (Annex B).

A section of the in-depth questionnaire (Part II at Annex B) collected information from all women of reproductive age group on their knowledge about the costs and benefits of preventive and curative care. The women were asked about their knowledge on family planning methods, ANC, diarrhoea and ARI of children, child immunization, signs of severity of diarrhea and ARI. They were also asked about their perception of benefits and costs of seeking such services and care. Attempts were made to determine whether they were aware of the positive and negative externalities of seeking various preventive and promotive health care services. The knowledge questionnaire also tried to understand whether the women know the providers in the locality and the price they charge.

Four different modules were used to collect necessary information on curative care. These are

- Questionnaire on antenatal care (Part III)
- Questionnaire on child immunization (Part IV)
- Questionnaire on family planning services (Part V)
- Questionnaire on other illnesses. (Part VI)

These questionnaires (Annex B) were used to collect the information on care seeking behavior for ANC, child immunization, different family planning services, and for general illnesses. These questionnaires collected information on last source used for these services and for illnesses, the amount of money spent,

willingness to pay additional amount of money for the services/care, and opinion about the quality of service and willingness to pay.

The health centers provide many different types of primary health care services. In general, UFHP clinics are supposed to provide the major components of ESP. Since the ESP list is quite long and each service can further be subdivided into sub-activities, the willingness to pay should address many different lines of activities. An additional dimension of all service activities is the “quality” of services delivered. If all the possible ESP activities with various indicators of quality are considered, the questionnaire will become too complicated and unmanageably large. To simplify the problem, the study had two alternative options: use a set of priority ESP components or select a number of ESP activities that the policy makers consider important for decision making. After discussions with the UFHP, the study decided to adopt the second approach. The UFHP identified a number of activities as crucial for their delivery system and the list was used for inquiring about the willingness and ability to pay.

The recall period for service utilization or health conditions was different for different services. The curative and preventive services delivered through the clinics had a recall period of two weeks. The satellite clinics are often held fortnightly in a location and therefore, to get some idea about the utilization of UFHP satellite clinics, the recall period should not be less than two weeks. The recall period for the utilization of ANC and immunization was one month in the survey.

The quality indicators used in the household survey were the perceived ‘quality indicators’ households themselves consider important. A survey on perceived quality provided the list of relevant quality indicators and the household survey used two to three important indicators to examine how the willingness to pay may change due to quality differences. Note that the quality issues discussed at the household level are the subjective evaluation of quality by households without any independent check of “quality” at the facility levels. So, the respondents were asked to evaluate the quality of service received in terms of specific quality indicators like waiting time, quality of provider, perceived quality of treatment/care, and cleanliness of the facility. The next step was to ask them about the additional amount of money they are willing to pay for improvements in one or two selected areas.

One problem of household survey in the community is the lack of “objective” information on clinics reported to have been used by the households. The willingness to pay for any services may be significantly affected by the “quality” of the services received recently. Although the household questionnaire makes an attempt to evaluate the quality of recently-used health center, the inter-household variability in perceptions may be very wide to affect the statistical validity of results. The likelihood of error in reporting quality is also usually high.

To crosscheck the household information on quality and willingness to pay, the study surveyed a number of clients who have used the UFHP facilities. The questionnaire on “facility survey” was used for collecting information on quality of care, type of services provided, information about the providers, the cost recovery strategy and charges for services, etc. The program managers of the facilities were interviewed by a physician of the HEP. Two out of the 10 facilities were selected purposely for this facility based exit survey. These two sites were in Dhaka (UFHP category A area) and Netrokona (UFHP category C area).

A small number of patients were selected for observation and exit interviews in six static facilities. Three investigators at every static clinic selected every third patient at the point of entry. They were also observed for the whole period of their stay at the facility. The major purpose of the observation was to find out at what point the clients are informed about the charges, who provides the information, who collects the fees paid by the clients, etc. The questionnaire also attempts to determine when the clinic staff assesses the ability to pay of the client. The observation of the patient noted the waiting time and time with the providers.

Clients were interviewed at the exit point by an interviewer (not by the interviewer who observed the clients during their stay at the facility) to collect information on the reasons for using the facility, total waiting time, total travel time and expenditure, total expenditure at facility, opinion about the level of user fees, willingness to pay an additional amount for the services with and without quality improvements. The

exit interviews were carried out in six clinics including the two clinics where quality questionnaire was administered. About 30 clients from each static clinic were interviewed. A total of 177 clients were interviewed at the exit points in the six selected static clinics. The purpose of this approach is to reduce inter-individual variability in recalling quality-related variables and the services received.

4.2 Data Processing and Analysis

A data entry program was used to enter the data directly from the questionnaire. The questionnaires were designed in such a way so that the information can be keyed in directly. The program for data entry was developed to handle data entry of large complex data sets. The program carries out consistency checks of the data fields as soon as they are entered. After the entry of the data, further cross-checking were carried out to ensure consistency of different components of the survey. The data sets entered were then converted into SPSS system files for analysis.

Using the sets of questionnaires as the guide, eight different data sets were created with appropriate identification fields in each of the records for linking. These eight data files are: census of households, information on selected households for in-depth survey, knowledge about health care services, information about health seeking behavior and willingness to pay for ANC services, for immunization, for family planning, for illnesses, exit interview information and facility survey information.

The data sets were analyzed using SPSS. Cross tabulation and regression models were used to analyze the data.

Defining the depth of knowledge about health care services

For the analysis of the knowledge information, an attempt was made to estimate the depth of knowledge regarding ANC, immunization, family planning and a number of childhood illnesses. The responses of women respondents were compared with a predefined list of correct responses. Depending upon the number of responses correctly identified, the respondent was assigned a knowledge score. If there are multiple questions on knowledge of specific health care services, the scores from all these questions were averaged together to obtain the overall knowledge score for each of the services.

Methodology followed to estimate willingness to pay

Willingness to pay for health care services were obtained by directly asking the respondents about the amounts they are willing to pay for specific health care services. The amount of money users of the service actually paid represents the lower limit of willingness. This method of defining the lower limit is problematic for high cost inpatient and outpatient services. For life threatening cases, amount actually paid may not necessarily represent the amount people will be willing to pay under different circumstances. However, the types of services being considered here are basically low-cost primary care services and actual pay out may be considered the minimum level of willingness.

Using the actual payments made by individuals as the starting value, the additional amount individuals reported willing to pay were added to define the maximum willingness to pay. For individuals who obtained free services, the maximum level of willingness was considered. The individuals were asked about their maximum willingness to pay for different services.

Methodology followed to define ability to pay

In this study, we have used two approaches of defining ability to pay for health care services. The first definition uses the actual payments individuals reported making for obtaining the care. Again, since the services considered are of primary care type, actual payment should be a reflection of what people are able to pay if options for choosing different types of providers with different prices exist in the community. In absence of choice of providers, actual payment will not reflect ability to pay. Since respondents in the survey mentioned presence of different types of providers in the same location, we can use the actual payment as a crude approximation of ability to pay.

The second definition of ability to pay is based on WHO type definition of ability, where total expenditure on medical care services as a proportion of total expenditure is used to define ability to pay. For poor economies, if the total health care expenditure is about 5% of total expenditure, the medical care services are considered affordable. In Bangladesh, total health care expenditure (including family planning) is about 5% of GDP of which about a third is provided through the government. In other words, the average out-of-pocket health care expenditure should be about 3.5% of household income. Although current expenditures on primary care services are relatively low, an efficient system in poor developing countries should allocate about a third of total health care expenditures on very basic health care services (see Khan, 1997). Therefore, allocation on basic health care services (outpatient care only) should be about 1.5% of total expenditure. This second definition of ability pay uses this cut-off point. A list of basic health care package has been defined and the modal or median prices of the services were estimated from the survey data. Total cost of the package was estimated for each of the households in the sample and cost-to-expenditure ratios were estimated. The households with cost-to-expenditure ratio exceeding 1.5% were categorized as 'unable to pay' the price set considered. The price set was changed to see the effect of price on the ability to pay.

5. DEMOGRAPHIC AND SOCIOECONOMIC CHARACTERISTICS OF THE SURVEYED HOUSEHOLDS

5.1 CENSUS INFORMATION

As mentioned in the methodology section, all households residing around the UFHP health centers were interviewed. The survey around 10 static clinics and 40 satellite clinics generated information from 14,994 households. The distribution of households among the three urban categories and by static and satellite clinic areas is presented in Table 3 below. Note that about 80% of all households in the census are from the satellite clinic areas. This is due to the higher weight assigned to satellite clinics in the survey method. The weights of urban categories were also predefined rather than using a proportional sample from each of the categories.

Table 3: Number of Households in the Census by Urban Category and type of Clinic

Urban category	Static Clinic area		Satellite Clinic area		
	No. of areas	# of Households	No. of areas	# of Households	
A	3	900	12	3,600	
B	3	900	12	3,600	
C	4	1,199	16	4,795	
TOTAL	10	2,999	40	11,995	

Table 4 reports the number and proportion of various demographic groups in the census by urban categories. The population in the satellite clinic areas has higher number of children per household than that in static clinic areas. As expected, the number of children per household was found to be highest in the satellite clinic areas of urban category C (0.64 per household). Urban category A shows higher number of under-5 children than category B. The proportion of households with at least one under-5 child varies in between 37% to 39% for static clinic areas and between 43% to 50% for satellite clinic areas.

Table 4: Demographic Characteristics of the Census Households by Urban Category

Demographic Characteristics	Urban Categories and clinic type							
	Urban category A		Urban category B		Urban category C		Total	
	Static	Satellite	Static	Satellite	Static	Satellite	Static	Satellite
HH with U5 children	337	1774	350	1559	474	2411	1161	5744
% HH with U5 child	37.44	49.3	38.9	43.3	39.5	50.00	38.7	47.88
Number of U5 children	414	2152	426	1844	566	3085	1406	8487
U5 children/HH	.46	.59	.47	.51	.47	.64	.47	.56
HH with Currently married women(CMW)	829	3330	803	3201	1067	4226	2699	10757
% HH with CMW	92.11	92.50	89.22	88.91	88	87.17	90.01	89.68
Number of CMW	918	3508	899	3489	1210	4596	3027	11593
# CMW/HH	1.02	0.97	1.0	.96	1.0	.96	1.00	.96
HH with pregnant women(PGW)	46	232	51	195	74	400	171	827
% HH with PGW	5.11	6.44	5.66	5.42	6.17	8.34	5.85	6.89
Number of PGW	47	234	52	199	74	404	173	837
No of PGW/HH	.05	.06	.06	.05	.06	.08	.06	.07
HH with women delivered in last 12 months(DW12)	66	398	78	374	127	565	271	1337
% of HH with DW12	7.33	11.05	8.75	10.47	10.60	11.87	9.04	11.15
Number of DW12	66	403	79	377	127	573	272	1353
No. of DW12/HH	.07	.11	.08	.10	.11	.12	.09	.11

Note from Table 4 that the number of currently married women per household remains at about 1.0 for all urban categories and clinic types. Urban category A shows slightly higher proportion of households with married women than other two categories. Proportion of households with pregnant women was highest in urban category C. The census information also indicates that the number of women delivering over the last 12 months varies from 7 per 100 households for urban category A to 12 per 1000 households for urban category C. Again, satellite clinic areas show higher number of women delivering over the last 12 months compared to the rates for static clinic areas.

Table 5 reports the construction material used by the households for constructing the residential houses in the catchment areas of health clinics. The construction materials of the residential house can be used as an indicator of socio-economic status of the households. Material used for walls appear to discriminate the socio-economic status better than the construction material of roof. It is clear from the table that the households living around the satellite clinics are much poorer than the households living around the static clinics. About 17% of all households in the catchment area of static clinics used leaves, bamboo or mud for constructing the wall. In the satellite clinic areas, this ratio was found to be 50%.

Table 5: Percent Distribution of Construction Materials used for Roof and Wall of Residential Structures in Static and Satellite Clinic areas (Census data)

Construction material	Urban area A		Urban area B		Urban area C		Total	
	Static	Satelite	Static	Satelite	Static	Satelite	Static	Satelite
Roof								
Jhupri/ bamboo/ clay	10.9	30.6	.3	.3	.5	10.7	3.6	13.6

Tin/ Tile	30.3	55.6	76.0	88.2	69.0	81.8	59.5	75.9
Concrete	58.8	13.8	23.7	11.5	30.5	7.5	36.9	10.6
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Total number	895	3584	895	3590	1197	4770	2987	11944
Wall								
Jhupri/ bamboo/ mud	20.0	67.1	20.3	32.8	13.0	50.0	17.3	50.0
Tin/ wood	3.4	3.3	18.4	23.8	32.9	21.3	22.8	16.7
Brick/ pucca	76.6	29.6	61.4	43.3	54.0	28.7	63.0	33.4
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Total number	895	3591	898	3591	1196	4777	2989	11959

Another indicator of low income of households is the participation of the main earner in the daily wage labor market. In Bangladesh, participation in the labor market as a daily wage earner is considered socially degrading and household members from middle and high socio-economic groups often do not work as a daily wage laborer. Table 6 reports the participation rate of households in wage employment by clinic location (urban categories) and clinic type. In static clinic catchment areas, about a quarter of households reported participation in the wage labor market. In the satellite clinic areas, the percent of households involved in the wage labor market was found to be much higher, about 55%. Again, the wage employment indicator of socio-economic status confirms that the households living around the satellite clinics of UFHP are relatively poorer than the households living around the static clinics.

The information in Tables 5 and 6 indicate that the UFHP clinics select relatively poor neighborhoods to set up the satellite clinics.

Table 6: Percent of Households reporting Daily Wage Employment of Principal Earner (Census of Households in Catchment Areas of UFHP Clinics)

Category	Static	Satellite	Total HH with main earner as daily wage earner	Total number # of HH
A	23.6	59.7	2360	4500
B	30.0	41.9	1779	4500
C	25.0	60.1	3181	5994
Total	26.1	54.5	7320	14994
Total number	782	6538	7320	14994

5.2 CHARACTERISTICS OF SURVEYED HOUSEHOLDS

As mentioned in the methodology of the survey, a number of households were selected from the census list based on some specific target characteristics. The study collected in-depth information from 3,004 households. Total number of individuals belonging to these households was found to be 15,927 implying

that the average family size in the UFHP survey areas was about 5.30. The average size of the family is slightly larger than the country average due to purposive selection of households with children, pregnant women, etc. The male to female ratio in the survey was about 1.0 but the ratio was more than 1.0 in static clinic areas (1.06) and less than 1.0 in satellite clinic areas.

Since the selection of households used presence of young children, pregnant women and mothers who delivered within 12 months prior to the survey, the age distribution will be biased towards the some specific age groups. For example, the percent of population in the age group less than five years should be higher in the sample compared to national proportions. Table 7 shows the age distribution of household members obtained from the survey. About 21% of the individuals in the survey belong to the age group less than five years. At the national level, the proportion should be no more than 15%. The proportion of population in the age group 15-39 years is also higher than the national level due to the emphasis of the survey on pregnant women and mothers with young children. The age distribution patterns of the individuals in the survey were found to be quite similar in all three urban locations.

Table 7: Age Distribution of Individuals in the Surveyed Households (in-depth Survey of Households in UFHP Clinics)

Age groups	Percent of individuals by Urban categories			Percent of total
	Category A	Category B	Category C	
Less than 5 years	21.7	21.5	21.0	21.4
5 to 9 years	12.7	11.3	13.1	12.5
10-14 years	10.3	8.7	9.2	9.4
15-39 years	43.6	44.9	42.6	43.5
40-59 years	8.7	9.2	9.4	9.1
60 years +	3.0	4.5	4.8	4.2
All groups	100	100	100	100

In terms of educational status of the household head, 61% reported more than five years of education in the static clinic areas while in satellite clinic areas the proportion was 27.8%. About three percent of household heads in static clinic areas and 1.2% in satellite clinic areas were women. In satellite clinic areas, about half of all household heads had no formal schooling. For static clinics the proportion was much lower, about 18.3%. The detail tables on age distribution, educational status by clinic type (static or satellite) and location (urban categories) are reproduced in Annex I (Table I-1 to I-7).

In terms of economic status of households, one third of all households in static health center areas and 57% of households in satellite clinic areas belonged to less than Tk.3,000 monthly expenditure group. On the other hand, 27.8% of households in static clinic areas and 5.6% in satellite clinic areas belonged to more than Tk.7,000 expenditure category. Clearly, the households living in the satellite clinic areas were much poorer than the households living in static clinic areas. In terms of urban categories, households living in category C health centers were the poorest. Annex table I-7 reports the percent distribution of the households by urban categories and clinic types.

Table 8 below reports the construction materials used in the construction of residential houses by the surveyed households. This table allows comparison of the socio-economic status of the surveyed households with the census information. If we compare the numbers in Table 8 with those in Table 5, we

find that the households selected for the in-depth interview were poorer than the socio-economic status of the population in general in the areas. For example, the census data show that 50% of households in satellite clinic areas used leaves, bamboo or mud to construct the walls and the proportion is about 62% among the surveyed households.

Table 8: Percent Distribution of Construction Materials used for Roof and Wall of in Static and Satellite Clinic areas by Surveyed Households

Construction material	Urban area A		Urban area B		Urban area C		Total	
	Static	Satellite	Static	Satellite	Static	Satellite	Static	Satellite
Roof								
Jhupri/ bamboo/ clay	13.5	33.8	.6	1.9	1.2	10.1	4.7	15.4
Tin/ Tile	43.3	62.6	88.4	95.8	76.3	85.1	70.2	80.8
Concrete	43.3	3.6	11.0	2.2	22.4	4.9	25.2	3.7
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Total number	178	773	181	667	241	964	600	2404
Wall								
Jhupri/ bamboo/ mud	27.0	78.4	26.5	49.8	19.9	56.7	24.0	61.8
Tin/ wood	2.2	5.0	25.4	23.2	35.7	20.1	22.7	16.1
Brick/ pucca	70.8	16.6	48.1	27.0	44.4	23.1	53.3	22.1
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Total number	178	773	181	667	241	964	600	2404

Construction material used for the construction of the residential houses shows a clear trend with household expenditure per month. For example, 25% of households in the expenditure category 1,500 taka or less per month had bamboo or leaves as roof of the residential house while only about 3% of households in the expenditure category Tk. 7,000 or more had bamboo or leaves as roof. Construction material of house also shows similar variation with economic status of households. For the poorest households, 75% used bamboo, leaves and mud for constructing the wall while it was about 18% for the richest group. It should be mentioned here that household expenditure pattern shows that less than 3% of households belong to the extremely poor category (less than Tk.1,500 expenditure per month) and only about 13% belong to the richest category (more than Taka 7,000 per month).

Table 9 reports the demographic characteristics of the surveyed households. The numbers in the table can be compared with those in Table 4 to see the extend of bias introduced in the sample to obtain households with children, pregnant women and women delivering in last 12 months. In the census, number of children per household was about 0.5 while in our sample, the number of children per household was more than 1.2. Only about 6% of households had one pregnant woman in the census but in the sample selected for the detail survey, 19% of households had pregnant women. The sample was purposely biased to obtain a higher number of households with pregnant women, women delivered in the last 12 months and children. These demographic characteristics represent our target population and such a bias provides a better understanding of health seeking behavior, willingness and ability to pay of these households.

Table 9: Demographic Characteristics of Surveyed Households by Urban Category

Demographic Characteristics	Urban Categories and clinic type							
	Urban category A		Urban category B		Urban category C		Total	
	Static	Satellite	Static	Satellite	Static	Satellite	static	Satellite
HH with U5 children	167	712	159	608	217	891	543	2211
% HH with U5 child	93.82	92.11	87.85	91.15	90.04	92.43	90.5	91.97
Number of U5 children	228	970	210	809	288	1308	726	3087
U5 children/HH	1.28	1.25	1.16	1.21	1.20	1.36	1.21	1.28
HH with C. married women(CMW)	178	773	181	667	241	964	600	2404
% HH with CMW	100	100	100	100	100	100	100	100
Number of CMW	205	829	208	734	285	1098	698	2661
# CMW/HH	1.15	1.07	1.15	1.10	1.18	1.14	1.16	1.11
HH with pregnant women(PGW)	31	141	33	106	49	233	113	480
% HH with PGW	17.42	18.24	18.23	15.89	20.33	24.17	18.83	19.97
Number of PGW	34	127	32	119	50	230	116	476
No of PGW/HH	.19	.16	.18	.18	.21	.24	.19	.20
HH with women delivered in last 12 months(DW12)	40	227	54	234	72	310	166	771
% of HH with DW12	22.47	29.37	29.83	35.08	29.88	32.16	27.67	32.07
Number of DW12	41	226	54	238	73	317	168	781
No. of DW12/HH	.23	.29	.30	.36	.30	.33	.28	.32

6. KNOWLEDGE AND UTILIZATION OF SELECTED HEALTH CARE SERVICES

The survey collected information on a number of curative and preventive health care services delivered through the UFHP clinics. It was agreed in a meeting prior to the survey that the study would concentrate on Antenatal Care (ANC), Child immunization, family planning and common childhood illnesses. The following sections summarize the results for each of the ESP services selected for in-depth analysis.

6.1 Antenatal care (ANC) services

This study selected all currently married women in the reproductive age group from the households in the sample to collect information about the use of ANC services. Using the methodology of household selection, 3004 households were selected from the 50 clinic catchment areas. In these 3004 households, the survey found 3148 currently married women in the reproductive age group. The knowledge questionnaire on ANC services was used to obtain information from all the 3148 women. The knowledge part of the analysis is based on this questionnaire.

6.1.1 Knowledge about ANC services

Table 10 reports the knowledge of women regarding ANC services. Most of the women in the survey knew about the need for ANC. For all women in the survey, 93.5% knew that pregnant women should go to a medical care provider even though they are not sick. The knowledge about the need for ANC was highest in category A clinic areas, where only about 2% of women did not know that pregnant women should get regular medical care or checkup. In category C clinic areas, more than 12% of women did not know about ANC.

Although most of the women knew about the need for ANC, they differed quite significantly in terms of depth of knowledge. About a quarter of all women who knew about the need for ANC could not mention the frequency of ANC visits. About 30% in all urban categories mentioned that a woman should have 3 to 5 ANC visits over the whole pregnancy period. About 25% thought that the number of visits should be once per month and 13% mentioned either less than three visits or more than 10 visits.

Table 10: Knowledge about Need for ANC and Number of Visits Over Whole Pregnancy

Urban Categories	Total Women	Need for ANC		No. of ANC visits over the pregnancy			
		Yes	No	3-5 times	6-10	Others	Don't Know
A	980 (100)	961 (98.1)	19 (1.9)	268 (27.9)	320 (33.3)	135 (14.0)	238 (24.8)
B	887 (100)	857 (96.6)	30 (3.4)	242 (28.2)	257 (30.0)	152 (17.7)	206 (24.0)
C	1281 (100)	1124 (87.7)	157 (12.3)	352 (31.3)	290 (25.8)	187 (16.6)	295 (26.2)

In terms of economic status of households, women from higher expenditure household groups show slightly higher level of knowledge than the women from poor households. The depth of knowledge is also higher for the higher expenditure groups. More than 50% of women in the expenditure group Tk.7,000 per month or above correctly reported the frequency of ANC visits during pregnancy. About 30% of the women in poorest expenditure group said that they do not know the number of times a pregnant women should visit health care providers for obtaining ANC services. This proportion was about 16% and 12% for

the expenditure categories Tk.5001-7000 and greater than Tk.7000 respectively. Annex table II-1 reports the results about need for ANC and frequency of ANC services.

Most of the women (about 91%) in the survey were aware of the benefits of ANC. The benefits mentioned by women were that the service helps to identify mothers' physical problems and position of the baby. Poor women appear to be less aware about the benefits of ANC than the women from richer households. Annex table II-2 shows that 10% of women in less than Tk 3,000 expenditure category per month did not know the benefits of ANC. For the highest expenditure category households, the proportion was found to be 5.1%.

About 92% of women reported that they know at least one provider of ANC services in the locality. Knowledge about the presence of providers in the area is quite similar in all the urban categories, although it is slightly lower in category C clinic areas. The knowledge about local availability of the service increases with the level of expenditures of the households. In the lowest expenditure category (less than Tk.3000 per month), 90% of women reported knowing at least one facility that provides ANC but the proportion was 97% for the highest expenditure group. Those who knew about the presence of a service provider, they mentioned 1.5 providers on the average. In other words, half of the respondents mentioned that they knew two facilities, which provided ANC services. Annex table II.3 reports the knowledge of women about possible sources of ANC care.

The table (Table II-3) also shows that 80% of all women mentioned public facilities as one of the ANC providers. This proportion varies with the degree of urbanization of the area. In most urbanized area (Category A), only 62% of women mentioned public facility as a source of ANC but in the least urbanized part of the country (Category C), 91% of respondents mentioned public facilities. Clearly, in category C areas, public sector is one of the most important sources of primary health care services. Another interesting pattern reported in the table is the percent of women mentioning UFHP as a possible source of care. In most urbanized area (category A), 62% of women mentioned UFHP clinic while in category C area only 29% mentioned it as a source. If we examine the economic status of the respondents, more than 45% of women from the expenditure category less than Tk.5,000 per month mentioned UFHP clinic as a source compared to less than 30% for households with expenditures exceeding Tk.5,000.

About 30% of women in our sample were aware of a facility where ANC was available free in their locality. About 46% women in "C" category knew where they could find free ANC services compared to 27% and 13% in categories "B" and "A" respectively. It is interesting to note that about a quarter of women could not mention whether the facilities in the locality charge money or not. This proportion is also identical in all three urban categories implying that presence of unofficial charges may not be the main reason for the lack of knowledge about charges (unofficial charges are likely to be present in public facilities and the category should have a higher proportion in C). An alternative explanation could be that the fee, if any, was paid by someone else accompanying the woman (see Annex table II-4).

Annex table II-5 reports the number of women who knew about a health center which provides fee based ANC services. About 76% of women were aware of at least one ANC provider charging money. Those who knew about at least one facility, 50% of them mentioned UFHP clinic. About half of them mentioned UFHP facility alone and the rest mentioned UFHP with some other clinics or providers. More relevant indicator of knowledge about the presence of a fee-for-service provider here is the proportion of women mentioning 'don't know' or 'no'. The proportions were 16%, 20% and 33% for urban areas A,B and C respectively. If per capita expenditure categories are considered, 28% from the lowest expenditure category and 13% from the highest expenditure category lacked knowledge about a facility charging fee for ANC.

In the survey, the respondents were also asked about their knowledge of charges in the facilities in the locality, if the services are not provided free of charge. Out of 2,388 women who knew at least one facility in the locality charging fee for ANC, 2085 gave their opinion about the minimum and maximum fees they think the health centers normally charge. The average of the minimum and maximum fee mentioned was Tk.30 and 47 respectively. It is interesting to note that the averages of the fee levels were found to be higher for the least urbanized area. On the other hand, average fee mentioned by the respondents increases with increasing expenditure of the household. The minimum and maximum charges mentioned were Tk.20

and 30 for the lowest expenditure group and Taka 54 and 90 for the highest expenditure group. Table II-6 reports the average prices mentioned by the respondents.

The respondents who knew about UFHP clinics were also asked about the knowledge on the fee charged by the clinics. The average price of UFHP clinic ANC services was reported to be Tk.14, much lower than the average minimum price mentioned for the clinics in the survey areas. Therefore, the current prices charged by UFHP are lower than the prices charged by other clinics. The respondents in urban category C reported a lower average price for UFHP services than the prices in A or B. The average price charged by UFHP for ANC show an increasing trend with economic status of the household. About 18% of women mentioning a price for UFHP clinics thought that the price was high and more than 60% thought that the price was 'OK'. Proportion of women reporting UFHP prices as 'high' declines with improving economic status of the households.

6.1.2 Utilization of ANC services

This study asked both the currently pregnant women and women who delivered within one year prior to the survey about their utilization pattern of ANC services. The number of women eligible as a respondent for the utilization module were 1541. Out of the total respondents, 945 women delivered during the past 12 months and the rest, 596 were pregnant at the time of the survey. Table II-7 shows that about 63% of women who delivered within 12 months prior to the survey sought ANC while 50% of women pregnant at the time of survey used ANC services. The lower rate among currently pregnant group may be due to early stage of pregnancy of some of the women. Proportion of women seeking ANC was found to be highest in Category B urban areas compared to the situation in A or C.

To make the two numbers comparable, we can use information on utilization of ANC by stage of pregnancy. For simplicity, let us assume that stage of pregnancy is equally distributed, i.e., the number of pregnant women in each month gestation period is the same. The number of pregnant reported in the survey are basically the pregnancies with more than three months of gestation. Distributing the current number of pregnant women over six months gives us 100 cases in each stage of pregnancy (months pregnant). According to the Demographic and Health Survey of Bangladesh 1996-97, the median number of months pregnant at first visit was 5 months. If we assume that all ANC visits are concentrated in five month stage of pregnancy, it is expected that the number of visits will increase by 100 if the overall ANC utilization rate is no less than 50% among pregnant women with gestation period less than five months. If we assume that the ANC seeking is 30% higher among the pregnant women with more than five months of pregnancy compared to other pregnant women, the increase in ANC seeking should be about 70. If we add this additional ANC visits expected for the currently pregnant sample (when they complete their pregnancy), the proportion of women seeking care should become 62%. Therefore, even with very conservative estimation of ANC utilization rate of currently pregnant women, the utilization rate should be no less than the utilization rate observed for women who delivered during the past one year.

Annex Tables II-8 and II-9 report the source of ANC care for the women who reported using the services. The utilization pattern of the sources appear to be quite different between the pregnant women and women delivering in the past 12 months. Over the last two-year period, the public sector as a source of ANC has declined in category A and category B of urban areas. In category C, role of public sector in the provision of ANC has remained more or less static. Another important trend that can be observed from these two tables is the significant expansion in the use of UFHP clinics in category B. In all categories, a higher proportion of women reported using UFHP clinics. Again, the relative decline in the use of public sector

was also low indicating that the expansion in the use of UFHP clinics was mainly at the expense of public sector.

Annex Table II-10 lists the reasons women have mentioned for using the health facility for ANC. Those who used the public sector clinics or providers, the modal reason was 'free service and free drugs'. The second most important reason mentioned was the presence of 'qualified provider' in the facility. For the users of private sector providers, the most common reason mentioned was the presence of 'qualified providers' followed by 'convenient hours' of the facility. For UFHP clinics, the modal group was that the facility is located 'near the house'. A number of other reasons mentioned may be considered almost tied for the second important reason. These are: convenient hours and presence of female providers. For other NGOs providing ANC services, no single reason turned out to be important. The users have mentioned location, convenient hours, presence of qualified provider, free service or drugs as important reasons for using the health centers. On the average, the respondents have mentioned two reasons for using the facility they have used.

Annex Table II-11 reports the expenditures incurred by the women in obtaining ANC services per visit. About a third of all women seeking ANC reported an expenditure of Tk.26 or more per visit. A significant proportion of women obtained ANC free of charge (24%). The use of free ANC services was more common among the poor households. About a third of them obtained ANC care free of cost. On the other hand, only about 15% of women belonging to household expenditure category Tk.5001 and above sought free ANC.

The average cost per ANC visit varies from Tk.18.30 for the lowest economic status group to Tk.94 for the highest economic status group (including the zero prices). On the average, the reported ANC visit cost was Tk.42. The reported average cost also varies considerably depending upon the source of care. For example, the average cost of ANC in private sector was reported at Tk.110 while the average costs at UFHP clinics and public facilities were only Tk.16 and Tk.17 respectively. Relatively higher average for public sector is basically due to high average cost of the cases who reported more than Tk.50 as ANC cost. This group may have confused ANC cost with costs associated with delivery. For example, one respondent mentioned Tk.450 as the fee paid to a public facility for ANC. Such a high level of charge is clearly not for ANC alone. Other NGOs charge about Tk.28 on the average according to the women using the facilities.

Annex Tables II-12 to II-14 report the average expenditure on ANC by urban categories A, B and C. In all urban categories, the average price of ANC was about Tk.42. The cost of ANC also show an increasing trend with better socioeconomic status in all areas. One of the most important differences among these three locations or urban areas is the use of free service. In urban category A, less than 20% reported obtaining ANC from public facilities free of charge while the proportions were 47% in urban category B and 81% for urban category C. For UFHP clinics, women have reported an average cost of Tk. 14 for urban categories A and C and about Tk. 20 for urban category B.

Table II-15 (Annex-II) cross tabulates source of ANC care with the economic status of the households. Among the lowest household expenditure group, 38% used the public facilities and another 34% used UFHP facilities. Only about 13% of the poorest group went to private providers for getting ANC. For the richest group, 56% went to private providers and another 21% went to public facilities. Utilization of ANC services from UFHP clinics show a systematic downward trend with increasing economic status. Less than 13% from the richest group used the UFHP facilities for ANC. The sources of ANC services by urban categories. Among the poorest households, 29% used public facilities for ANC while the proportions were 35% and 45% for the urban categories B and C respectively. In all areas, utilization of public sources for ANC declines with economic status but the rate of decline was lower in urban categories C and A compared to that in B. In urban categories A and C, the UFHP clinics appear to be equally popular among the expenditure groups below Tk.7,000. In urban category B, the UFHP clinics appear to be equally popular among all economic groups.

To understand the factors that affect the utilization decision, i.e., whether to use ANC or not, a logistic regression model was estimated with the utilization of ANC defined as a dichotomous variable (used ANC=1, did not use=0). The model shows that the utilization of ANC is affected by household expenditure

level (upto Tk.6,000), whether the woman has five years of education or not, knowledge score of the woman, knowledge about the presence of a health center that provides free ANC care. The price charged by the clinics for ANC care was not significant statistically in the model. Higher than 2.0 odd ratios were obtained for education of the woman, knowledge about ANC, whether the woman knows the benefits of getting ANC, and whether the woman thinks that non utilization of ANC by a pregnant woman has other social implications. Therefore, although price and distance variables were statistically significant at 8% level or better, the relative impact of the variables were very small implying that price in the market place was not an important variable in explaining non-utilization of ANC services.

6.1.3 Willingness to pay for ANC services

To understand the willingness and ability to pay for ANC services, the first step should be to examine the current out-of-pocket expenses and the opinion of the women and the level of fees they have paid recently. Annex table II-16 reports the opinion of ANC service users by economic status and by the source of service. About a fifth of all users thought that the price they paid was too high and two-thirds considered the price as 'just right'. Economic status of the household does not seem to affect the opinion in a systematic manner. If the source of service is considered, a higher proportion of NGO service users thought that the prices they charged were 'just right'. About 78% of the users thought that the prices they have paid were not 'too high' indicating that the average amount paid will be a good starting point for the estimation of willingness.

Table 11 reports the willingness of the women to pay more for the ANC services. Note that the willingness question was asked to those women who have used the ANC services in the recent past. It is interesting to note that about 60% of women from poor households reported their willingness to pay some additional money for the services. This proportion tends to increase with household income excepting the expenditure category Tk.5,001-7000. Proportions of women mentioning willingness to pay additional money were quite similar for all types of facilities, at around 60%. For public facilities the proportion was 66% and for UFHP clinics, it was 60%. In category C urban areas, 65% of women said that they will pay more money for ANC while the proportions were 62% and 58% for category A and B areas respectively.

Table 11: Willingness to Pay Additional Money over and above the Current Costs of Obtaining ANC by Economic Status of Households, Source of Care and category of urban centers

		<u>Will you pay more money for the ANC if needed?</u>				<u>Total number</u>
		<u>Yes, willing to pay more</u>		<u>No, will not pay any more</u>		
		<u>Number</u>	<u>Percent</u>	<u>Number</u>	<u>Percent of women</u>	
<i>HH Expenditure groups</i>						
Tk.3,000 or less	147		57.6	108	42.4	255
Tk.3,001-5,000	124		60.2	82	39.8	206
Tk.5,001-7,000	59		58.4	42	41.6	101
Tk.7001 or above	86		76.1	27	23.9	113
TOTAL	416		61.6	259	38.4	675
<i>Source of care</i>						
Public facility		82	65.6	43	34.4	125
Private facility		124	60.2	82	39.8	206
UFHP Clinic		146	59.6	99	40.4	245
Other NGOs		63	64.3	35	35.7	98
Others		2	100	0	0	2
<i>Urban Categories</i>						
Category A		130	61.6	81	38.4	211
Category B		134	58.0	97	42.0	231
Category C		153	65.4	81	34.6	234

The charges paid by individuals were added with the additional money they reported willing to pay to derive the maximum willingness to pay. The average of the willingness to pay varies with the source of care, urban category in which the household is located and the economic status of the household. The

average willingness to pay is also affected by the price the women have paid during the last visit. If the service was obtained free of charge, the willingness to pay was also lower. Table 11 reports the average willingness to pay for ANC by household economic status, urban location and whether or not they paid for ANC during the last visit.

The median value of willingness to pay was found to be about Tk.40 for public sector, Tk.150 for the private sector and Tk.40 for NGOs if we consider only those women who paid for their last ANC visit. If the last visit was free, the willingness to pay amounts were significantly lower, Tk.13 for public sector, Tk.27 for private and Tk.17 for NGO facilities. The results are summarized in table II-17 in the annex.

Table 12 reports the average willingness to pay for ANC services at the UFHP clinics by economic status of households, urban categories and whether or not the women paid any money during the last ANC visit. Among the women who paid some money during the last ANC visit, the average willingness to pay varies from Tk.22 for the lowest economic category to Tk.41 for the richest group. There is a clear increasing trend in willingness numbers with improving economic status. Since the number of women who did not pay for ANC last time at UFHP clinics are very small, the average willingness numbers for them are not reliable.

Table 12: Average Willingness to Pay for ANC Services at UFHP Clinics

	<u>Women who paid for service</u>		<u>Women who did not pay for ANC</u>	
	<u>Average willingness (Tk)</u>		<u>Average willingness (Tk)</u>	
	Number	Taka	Number	Taka
<i>HH Expenditure levels (Tk/month)</i>				
Tk.3000 or less	122	21.7	9	10.6
Tk.3,001-5000	76	24.7	2	5.0
Tk.5,001-7000	30	30.2	0	****
Tk.7,001+	16	41.3	1	20.0
<i>Urban Categories</i>				
Category A	77	22.7	4	5.0
Category B	55	34.6	4	12.5
Category C	113	21.8	4	13.8
Average	245	25.0	12	10.4

6.1.4 Factors affecting willingness to pay

A number of regression models were run to examine the relationship among willingness to pay for ANC services and various individual and household characteristics. The urban categories were also included in a number of regression models. The regression results indicate that if we control for household expenditure levels, educational status of women, etc., urban location shows no impact at all on willingness to pay. However, inter-location variability exists in terms of the effect of other independent variables. Table 13 below summarizes the results of the regression model.

Note from the table that knowledge about the ANC service affect the WTP significantly in all areas and the quantitative value of the effect is also quite high. The knowledge index was constructed by combining the responses of two questions in the questionnaires, question numbers 203 (in your opinion how many times a pregnant woman should go for check up over the whole pregnancy) and 207 (list the components of ANC activities, the activities performed by the provider during an ANC visit). A predefined list was prepared to represent the highest degree of knowledge. In each of these questions, the respondents can get the highest score of 1.0 if the response exactly matches the predefined values or list. Deviation from the list will be assigned a value less than 1.0. The knowledge index was calculated by taking the average value of the two scores. In the survey, the average knowledge score of women was quite low, about 0.2 even though a number of women obtained scores as high as 0.8. Therefore, a 10% increase in knowledge index from the mean value will increase the willingness to pay for ANC services by about Tk.1.25.

Access to free care reduces WTP significantly. Those who obtained free care during the last ANC visit, their WTP is about Tk.14 lower than the others who obtained care at a fee. The effect of access to free care was strong in urban area A and B but the variable shows no impact in urban area C.

Education of the woman seeking care is another significant variable in affecting WTP. Those who have more than five years of education are willing to pay Tk.50 more than others. It is important to note that the coefficients of education in three urban categories were almost identical. Clearly, women's educational status is an important variable affecting WTP even when we control for the service specific depth of knowledge.

Household expenditure levels were not significant in all the equations estimated excepting the model for urban location C. In general, economic status has no impact on WTP for ANC services but in the least urbanized part of the country (among urban areas), household expenditure level turns out to be statistically significant. Urban location C is relatively poor (average expenditure in C was reported at about Tk.4500 compared to Tk.5,800 in category A). In category C areas, increase in the household economic status or expenditure levels by 10% will increase the WTP by about Tk. 1.81.

Table 13: Effect of Independent Variables on WTP for ANC

Independent Variables	All locations		Urban location A		Urban location B		Urban location C	
	Coeff	t-value	Coeffi	t-value	Coeffi	t-value	Coeffi	t-value
Knowledge Index	62.12	3.14	54.31	1.89	72.14	2.32	66.64	1.74
Free care last time	-14.1	7.23	-27.3	-1.89	-35.9	-3.14	-2.6	-20
Education GT 5yrs	52.60	7.09	35.80	3.24	51.19	4.75	51.59	3.22
HH Exp	.0002	0.90	.0003	1.46	-.0001	-.51	0.004	2.36

Constant	26.89	3.61	25.89	2.35	29.66	2.54	11.27	0.76
R-square		0.102		0.113		0.142		0.123
F-value	22.92		7.22		10.55		10.95	

6.2 Immunization

All mothers in reproductive age group were asked a number of questions to understand their knowledge about child immunization. Almost all women reported that they knew about the need for immunizing children by 12 months of age. Willingness to pay for immunization services were also derived through the interview of mothers. As mentioned above, 3148 women responded to the immunization related questions.

6.2.1 Knowledge about Child Immunization services

Most of the women in Bangladesh know about the need for childhood immunization by age 12 months. Annex table III-1 shows that 98% of women knew about the need for immunization. The proportion remains similar for all household expenditure categories and urban location of the facility.

When asked about the source of immunization services in the community, 98% of the women mentioned that they knew where to get their children immunized. The knowledge about the source of immunization services is high in all urban areas and for all household expenditure groups. Therefore, women in Bangladesh are well aware of the sources of immunization services. On the average, the respondents mentioned 1.45 sources per woman.

The most common source mentioned by the women was the 'public facilities' followed by the UFHP clinics. Other NGOs were also mentioned by about a quarter of all women. Private facilities were mentioned by only 5% of respondents and most of these respondents live in urban category B. Table III-2 reports the knowledge of immunization source by urban categories and economic status of households.

Ninety nine percent of women in the survey knew about the benefits of childhood immunization. More than 73% of the respondents mentioned that immunization prevents diseases of children. Table III-3 reports the responses of the women on the benefits of immunization. Clearly, women in Bangladesh are well aware of the benefits of immunization.

6.2.2 Utilization of Immunization

Table III-4 in the annex shows the distribution of immunized children in the survey. The survey asked all mothers about the immunization status of children of age 11 months. About 31% of children were reported to be not immunized in the survey. Out of 955 children eligible for immunization, only 658 were immunized. It appears that almost perfect knowledge about immunization did not translate into actually obtaining immunization. In terms of proportion of children immunized, urban category B was the best followed by urban category A.

Those who obtained immunization during the past three months, the respondents were asked about the source of immunization. Only 446 cases obtained immunization within three months prior to the survey. Out of these immunized cases, 48% obtained their last immunization from the public facility and 32% obtained that from the UFHP clinics. Only 4.5% reported obtaining immunization from private facilities. Other NGOs are also important in the provision of immunization; they provided immunization to 15% of children. Table 14 shows the source of immunization for the children. Note that mothers in category C did not use any private sector.

Table 14: Source of Immunization by Urban Categories for children who Received Immunization with Three Months Prior to the Survey

Urban Category	Public Sector		Private Sector		UFHP Clinics		Other NGOs	
	No.	%	No.	%	No.	%	No.	%
Category A	45	33.3	5	3.7	49	36.3	35	25.9
Category B	85	51.2	15	9.0	39	23.5	26	15.7
Category C	85	58.2	0	0	54	37.0	7	4.8
Total	215	48.1	20	4.5	142	31.8	68	15.2

Annex Table III-5 reports the reasons for the selection of the provider for getting immunization services for children. The modal responses for the selection of the facility chosen by mothers were: close to the house for public sector, other NGOs and UFHP, free service or free drugs for public sector and other NGOs, convenient hours for private facilities. For other NGOs, convenient hours and free service or drugs were also important. For UFHP clinics, close to the house is the predominant reason (52% mentioning the reason).

About 50% of all women getting immunization for children with the past three months got the service free of cost and another 44% received the service by paying less than Taka 10. In public facilities about 73% of immunizations were obtained free. In UFHP clinics, 37% received free immunization among all those who obtained immunization from UFHP. The proportion of children getting free immunization appear to be independent of expenditure levels of the households. In all household categories, the proportions were around 50% excepting the expenditure category Tk.3,001 to 5,000. Annex Table III-6 reports these numbers.

The table also shows the average cost paid for immunization by household economic status and sources of care. The average cost of immunization do not show any systematic trend with income. The average charge for one immunization visit was Tk.3.73. Cost of immunization varies quite significantly by source of care. The average cost of immunization in the public sector is Tk.1.42 and in other NGOs, it was Tk.7.63. The UFHP clinics charge about Tk.5.00 for immunization on the average. It is interesting that the average cost of immunization in the private sector is also quite low, lower than what other NGOs were charging.

6.2.3 Willingness to pay for immunization

Annex Table III-7 shows the opinion of mothers about the immunization charges. Table III-6 shows that 225 mothers reported paying money for obtaining immunization for their children. These mothers were asked whether they feel that the price they have paid was too high or not. Although the immunization charges are low, 17% of mothers felt that the charge was too high. Almost 70% of the mothers were of opinion that the charges they have paid were 'alright'. Excepting the richest household group, about 20% mothers from all other groups felt that the prices were too high. About a quarter of all mothers from expenditure categories Tk.5,000 and above reported that the price they paid were too low. About a fifth of UFHP users thought that the UFHP price for immunization was too high and another one fifth thought that the UFHP price is too low.

Table 15 below shows the number of women who said that they are willing to pay more for immunization services, if needed. About 56% of the mothers who has paid some money for immunization during the last visit were willing to pay more money. The proportion willing to pay more money remains at around 50 to 60% for expenditure categories less than Tk.7,000. For the highest household expenditure group, the proportion willing to pay more money jumps to about 84%. The proportion willing to pay more was about

65% for both public and private providers and about 50% for UFHP and other NGOs. Proportion willing to pay more for immunization was lowest in category A areas and highest in the category B areas.

Table 15: Willingness to Pay Additional Money over and above the Current Costs of Obtaining Immunization by Economic Status of Households, Source of Care and category of urban centers

		<u>Will you pay more for immunization if needed?</u>				<u>Total number</u>
		<u>Yes, willing to pay more</u>		<u>No, will not pay any more</u>		
		<u>Number</u>	<u>Percent</u>	<u>Number</u>	<u>Percent of women</u>	
<i>HH Expenditure groups</i>						
Tk.3,000 or less	42	50.0		42	50.0	84
Tk.3,001-5,000	42	50.0		42	50.0	84
Tk.5,001-7,000	14	58.3		10	41.7	24
Tk.7001 or above	27	84.4		5	15.6	32
TOTAL	125	61.6		99	44.2	224
<i>Source of care</i>						
Public facility	37	64.9		20	35.1	57
Private facility	12	66.7		6	33.3	18
UFHP Clinic	44	50.0		44	50.0	88
Other NGOs	31	51.7		29	48.3	60
Others	1	100		0	0	1
<i>Urban Categories</i>						
Category A	52	49.5		53	50.5	105
Category B	56	62.9		33	37.1	88
Category C	17	56.7		13	43.3	30

The average willingness to pay for immunization was obtained from the users of the service. Table 16 reports the average willingness to pay for immunization by household expenditure categories and urban locations. The table also shows the average willingness by source of service and whether or not the mother paid for child immunization during the last visit. The average WTP for immunization were found to be Tk.11, Tk.15 and Tk.14 for public, private and NGO providers for those who paid some money in the last visit. The average willingness tends to increase with economic status of households. For the public sector, the average WTP is almost identical in all urban locations A, B and C. The average willingness to pay remains about Tk.7 to 8 for the mothers who did not pay anything during the last visit.

Table 16: Average Willingness to Pay for Immunization by Socioeconomic Status of Households, by Source of Service and by Urban Category

	Willingness to pay for immunization services in UFHP areas					
	Those who paid for service			Those who did not pay for service		
	Public	Private	NGOs	Public	Private	NGOs
<u>HH Expenditure groups</u>						
Less than Tk.3,000	11.80	10.88	15.17	7.79	--	6.70
Tk.3001-5000	10.00	15.50	11.83	8.38	10.00	7.50
Tk.5,001-7000	9.30	9.00	11.42	9.27	--	5.00
Tk. 7001+	11.40	26.25	16.67	13.75	5.00	7.50
<u>Urban category</u>						

Category A	11.20	16.80	16.60	5.30	5.30	---
Category B	10.10	14.60	11.40	8.40	10.00	6.90
Category C	10.00	---	6.90	7.60	----	-----
Total	10.60	15.10	13.90	7.70	7.506.90	

6.2.4 Factors affecting the Willingness to pay for immunization

The regression model estimated to see the impact of various factors on the WTP for immunization services is reproduced below:

$$\text{WTP for immunization} = 10.87 + 0.0007 * \text{EXP} + 1.497 * \text{EDUC} + 2.716 * \text{BENEFIT} \\ - 4.693 * \text{FREE} - 0.209 * \text{PREV}, \quad \text{R-sq} = 0.145$$

In the equation EXP represents expenditure level of the household if expenditure per month is Tk.6,000 or below, EDUC is a dummy variable to indicate whether the woman has more than five years of education or not, BENEFIT is a knowledge variable indicating that the woman could identify the correct benefits of immunization, FREE is a dummy variable to show whether the woman knows about a health center that provides free immunization and PREV is a knowledge variable that shows whether the woman could name the vaccine preventable diseases correctly or not. Note that all these variables are significant at 10% level or better. As expected, household expenditure levels increase willingness to pay by Tk.0.0007 for each Taka increase in expenditure. Five or more years of education of women increases the WTP for immunization by Tk.1.50, knowledge about the presence of a free facility reduce WTP by Tk.4.70, etc.

Regression models were also run for the urban categories separately to see whether the WTP function is different in different urban areas. In urban category A, all variables other than the knowledge about the presence of a free provider becomes statistically insignificant. Therefore, in metropolitan areas income, education etc. have no impact on WTP for immunization services. The results are quite similar for urban location B as well. The only significant variables in explaining WTP for immunization in urban location B were the knowledge-related variables. In urban location C, knowledge, education turns out to be important in explaining WTP.

6.3 Acute Respiratory Infections (ARI) and Diarrhoea

6.3.1 Knowledge about ARI

About 48% of the women could identify the three major symptoms of ARI (unprompted) in the survey. In urban location A, a higher proportion of women could identify the symptoms (56%) while in urban category B about 42% could mention the three major symptoms. Annex Table IV.1 shows the proportions by urban categories.

Table IV-2 in the annex reports the source of care for ARI cases in the UFHP areas. More than 95% of women knew at least one provider for ARI related care. Interestingly, the knowledge about source of care was slightly higher in urban category C than in categories A and B. Three quarters of all women mentioned private facilities as a source while 47% mentioned public clinics or facilities as a source. The UFHP clinics as a source of care for ARI was mentioned by only 14% of women. It appears that the women in the locality do not consider UFHP clinic as the source of curative services.

The table also shows the knowledge about source of care by economic status of households. The

knowledge about sources is also similar for all economic groups, almost 95% women in all household expenditure categories knew about a source of care. The pattern of specific sources mentioned was also similar for all four expenditure groups. The average number of sources mentioned per woman in the survey was about 1.4.

Annex Table IV-3 reports the knowledge of the women surveyed on availability of free medical services for the treatment of ARI. Only 21% of women knew at least one provider who supply service free of cost. The knowledge about the presence of free provider is much higher in urban category C than in other two urban categories. In urban category C more than a third of all women mentioned that they knew a free provider while in A and B it was about 10%. If we examine the knowledge about free care provider, 24% in the lowest expenditure category knew a provider but it was found to be about 18% for all other expenditure categories. Availability of free care may be higher in urban location C explaining the higher knowledge there. The poorest in the community probably try to find out about the availability of free care.

Although a high percent of women did not know a facility where ARI treatment was provided free of charge, about 90% knew a facility where ARI treatment is provided for a fee. This type of knowledge about market situation is slightly lower in category C urban areas. Only 16% of women mentioned UFHP as a possible source of fee based ARI treatment. In the knowledge question on the source of care, some women did not mention UFHP clinics as a source but when asked about fee based sources UFHP clinics were mentioned. About 20% of women in the expenditure category Tk.7,000 or more knew UFHP as a source of ARI treatment facility on payment of fee. This proportion is around 15% for all the other expenditure groups.

The average of maximum reported prices charged for ARI treatment was Taka 64.76 while the average of minimum was Tk.40.64. The averages of the minimum and maximum prices do not show any systematic trend with the degree of urbanization of the location (urban locations A,B and C). The average prices show an increasing trend with expenditure levels of the households. For the lowest expenditure category the averages of minimum and maximum prices were Tk.31 and 50 respectively but the averages for the highest expenditure group were Tk.63 and Tk.100. The average price mentioned for UFHP was less than Tk.15, much lower than the average of the minimum prices in the locality. The average UFHP price mentioned was similar for all economic groups. The average of UFHP clinic price mentioned in urban location C was lower than in other two areas. Those who mentioned that they knew about UFHP clinic charges for ARI treatment, they were asked about their opinion whether the price was low or high. About 17% of women who knew about UFHP clinics mentioned that the price was too high and 14% thought that the price of UFHP clinics was low. Annex Table IV-5 reports all these numbers by urban category and household expenditure groups.

6.3.2 Knowledge about diarrhoea

About 97% of women could identify a place where treatment for diarrhoea was available. This knowledge is similar for all urban areas and household expenditure groups. Most of the women mentioned public and private facilities as sources of care for diarrhoea. Only 6% of women reported UFHP clinic as a possible source of care. This finding again indicates that the women in UFHP clinic areas do not consider the clinic as a source of curative care services. Annex table IV-6 reports the knowledge about source of care for diarrhoea.

About 35% of the women reported that they were aware of facilities where treatment for diarrhoea was available free of charge. In urban category C, almost 50% mentioned that they knew a free facility for treating diarrhoea but the proportion was less than 30% for urban categories A and B. Table IV-7 shows that there is no systematic trend about the knowledge of the free providers by economic status of households.

Annex Table IV-8 shows that 78% of women were aware of at least one provider in the locality who deliver treatment for diarrhoea by charging money. This proportion was lowest in urban category C (68%) and highest in urban category B (90%). The UFHP clinics were also mentioned as a source of care in exchange for money by only 8.5% of respondents. The response was similar in urban category A and C but lower in B. With the increase in the economic status of households, a higher proportion of women identify UFHP clinics as a source of care. Less than 8% of women in the lowest expenditure category mentioned UFHP clinics as an option but the proportion was about 13% for the highest expenditure group.

To summarize, women living in the catchment area of UFHP clinics do not consider the clinics as major provider of curative care. The UFHP clinics are mentioned very often for ANC and immunization but not for ARI and diarrhoea.

6.3.3 Utilization of Curative Services

The survey obtained information about illnesses in the household over the previous two weeks (two weeks prior to the survey). The respondents were asked to mention all illnesses in the household even the very minor types and chronic conditions. In the 3,004 households in the survey, 2257 cases of illness was mentioned. Therefore, the number of illnesses per household over the two-week period was 0.75. The prevalence rate of illness among the survey individuals was about 141 per thousand.

On the average, 50% of all illness cases did not seek medical attention and the proportion not seeking care varied from about 45% in urban category A to 54% in urban category C. Among the users of medical care, more than 80% sought care from private providers and another 12% obtained care from public facilities. Only about 3% of illness cases obtained care from the UFHP clinics in the location. It is consistent with the response obtained from the women about their knowledge of sources of care for curative services. The pattern of utilization of various sources are quite similar in all areas of urban categories. Table IV-9 reports the medical care seeking pattern of the survey population by urban categories and by sources of care.

Annex Table IV-10 reports the average cost of care for illness episode. The average cost of care was highest in urban category B followed by urban category A. It is interesting to note that the average cost in public facilities was also quite high. This may indicate that the severity-mix of the illnesses seeking care from public facilities may be higher than the severity-mix in other sources. The UFHP clinics show relatively low cost and the severity of cases showing up in UFHP clinics, by definition, should be very low. In this sense, these average cost numbers are not directly comparable. However, without more detail information about the severity of illnesses, it is not possible to correct the average cost values for the illness condition. Therefore, for comparing the average cost of limited curative care services, we should use the modal value of costs rather than the average cost or the median value.

6.3.4 Willingness to pay for curative care

Willingness to pay for curative care does not show any relationship between willingness to pay and educational status of women, knowledge about illnesses, etc. Only variable that turns out to be statistically important in explaining WTP is the expenditure level of households. The effect of household expenditure on WTP turns out to be quite significant, about 0.05 for each Taka increase in expenditures. Therefore, increase in the household expenditure by Tk.100 per month will increase the willingness to pay for curative care by about Tk.5. The regression equation estimated for WTP is given below. Note that no other variables, educational status, knowledge about ARI, knowledge about diarrhoea are not statistically significant in the model.

$$\text{WTP} = -153.46 + 0.05 * \text{EXP} + 99.58 \text{ EDUC} + 54.34 \text{ KNOW-ARI} \\ + 111.75 \text{ KNOW-DIA} \quad \text{R-sq}=0.009$$

6.4 Family Planning Services

6.4.1 Knowledge about Family Planning

Table V-1 shows the knowledge of the surveyed women about the source of family planning services and supplies in the locality. About 97% of the women knew places where they could get family planning methods. The knowledge about the source of family planning services was similar in all urban categories A, B and C. In all these areas about 96% women knew where to get family planning services and supplies.

When the women were asked to name the sources, 67% mentioned private providers as a source and 60% mentioned public facilities as a source. About 46% of women also mentioned UFHP clinics as a source of

family planning services and supplies. Those who knew about a source, they mentioned 1.9 sources per woman. On the average this is the highest number of sources mentioned among all the different types of services considered in this study. Therefore, women not only knew about the source of care, they knew more than one source of family planning services and care. Knowledge about family planning appears to be the best among limited curative care, immunization, ANC services, etc. As expected, 75% of women mentioned public facilities as a source of care in urban category C while the proportion was less than 40% in urban category A. Knowledge about UFHP clinics as a source of family planning services was highest in urban area A. Table V-1 also shows that a relatively higher proportion of women from higher economic status mentioned private sector as a source (more than 70% compared to 63% for the lowest expenditure category).

Table V-2 reports the proportion of women who mentioned that they knew at least one provider who supplies family planning services free of charge. Only about a third said that they know a free provider in their area. About a quarter did not know whether the providers in the locality were free or not. In the urban category A only about 10% reported knowing a free provider but in urban category C more than 50% knew a free provider of family planning services. Again, this knowledge may be related to the supply situation in the market place. Knowledge about a free provider was relatively higher among the lowest expenditure category households.

6.4.2 Utilization of family planning services

The women who were currently using family planning methods were asked about the source of family planning services and supplies. About 24% of women mentioned public sector facilities as a source. Private providers and facilities were mentioned by about 38% of women and 29% mentioned UFHP clinics. Other NGOs and other providers constituted only a very small proportion of total, less than 10% of the current users. The source of care is also considerable different among the three urban categories. In urban category A, 12% mentioned public sector as a source but in category C about 36% mentioned public sector as a potential source. The UFHP clinics was mentioned as a source the women used by 35% of women in A but by only 23% women in C. Table V-3 in the annex gives the detail about the source of family planning services by urban categories.

In the survey 305 women mentioned public sector as the source and 58% of them went to public facilities to get pill or condom. About 21% in the public sector users adopted injectables as a family planning method and 15% chose sterilization. The women selecting private sector as the source were basically pill users (96%) and UFHP clinic users were equally split between adoption of pill or condoms and injectables. The utilization of family planning services were almost similar in other NGO providers and other providers. Among the pill and condoms users, more than 50% went to the private sector followed by the public sector. For injectables, UFHP clinics were the principal suppliers accounting for 70% of total injectable users in the survey. For IUD/Norplant and sterilization, public sector is the predominant supplier. Annex Table V-4 reports the source of supply by type of family planning method adopted by women in the survey.

Annex Table V-5 is the frequency distribution of the reasons mentioned by women for the selection of the specific provider. On the average, family planning users mentioned 1.5 reasons per woman for selecting a facility or provider. If we use the modal reason, the reason for selecting public facility is because the services are provided free of cost. The modal reasons for private, UFHP and other clinics were convenient time of operation, close to the house and convenient time of operation respectively. Privacy has been mentioned by 11% of responses for the reason for selecting private providers but for UFHP clinics the proportion of women mentioning privacy being maintained by 1.2% of responses, less than the proportion of responses in this category for public sector. Cleanliness and lower waiting time was mentioned by only few individuals, less than 3% of all respondents. It appears that for the women in Bangladesh, convenient timing, close to the house, provision of free service and maintenance of privacy are much more important than cleanliness of the clinic, lower waiting time, and well-behaved provider.

Annex Table V-6 reports the distribution of expenditures incurred by women for obtaining family planning services and supplies. About a quarter of all women obtained the family planning services free of cost.

More than 55% of family planning services users paid Taka 10 or less. The average cost of a family planning visit was found to be about Tk.8.00. A higher proportion of women from the lowest household expenditure group obtained free service and supplies (27%) than that in the highest expenditure group (16%). The average cost of family planning also increases with better economic status of households. The women from the lowest expenditure category had paid Tk.6.4 on the average and the average cost was Taka 12.9 for the highest household expenditure group.

In terms of the sources of care, almost all free care was obtained from the public providers. All women who mentioned getting free service 85% of them obtained that from the public sector. Similarly, all women who got care from the public sector, 83% got the service free. Only 2.4% of users of UFHP clinics mentioned that they obtained family planning services free of cost. Almost all of the UFHP clinic users paid less than Taka 10 (92% of women). The women who mentioned that they paid more than Tk.25 for family planning about 95% of them paid that amount to private providers. Private sector also dominates in the cost category Taka 11-25; about 74% of those who paid an amount within this range obtained their service from the private sector.

The average costs of family planning services vary quite significantly among all the sources of care. The average cost in the public and private sectors were Taka 1.00 and 14.00 respectively. For other providers, the average price was about Taka 7.00.

6.4.3 Willingness to pay for family planning services

Table V-7 in the annex reports the opinion of women about the charge they have paid for the family planning services. About a fifth of all women mentioned that the price they have paid for family planning was too high. A slightly higher proportion from the lower economic categories mentioned this than the women from relatively higher expenditure groups. Most of the women, about 70%, mentioned that the price they have paid is alright. Economic status of households does not appear to be related with the proportion of women mentioning that the prices they paid were ok. About 12% women using UFHP clinics and 16% using public facilities mentioned that the prices they have paid were too low.

Table 17 below reports the opinion of the women when they were asked whether they will pay more money for family planning services if needed. About 52% of women mentioned that they will pay more than what they have already paid to obtain the family planning services. The willingness to pay more increases with the economic status of the household. About 46% of women from the lowest expenditure group and 70% of women from the highest expenditure group mentioned their willingness to pay more, if needed to ensure service availability. Willingness to pay more was found to be about 50% or above for all sources of care excepting the category 'other'. In fact, this category was also considered to have too high a price. The sample size in this category is quite low and this result may be due to the low numbers in the cells. Proportions of women mentioning that they are willing to pay more were around 50% for all urban categories (A, B and C).

Table 17: Willingness to Pay Additional Money over and above the Current Costs of Obtaining Family Planning Services by Economic Status of Households, Source of Care and category of urban centers

<u>Will you pay more for family planning if needed? Total</u>			
<u>Yes, willing to pay more</u>	<u>No, will not pay any more</u>	<u>number</u>	
<u>Number</u>	<u>Percent</u>	<u>Number</u>	<u>Percent of women</u>

<i>HH Expenditure groups</i>					
Tk.3,000 or less	185	46.4	214	53.6	399
Tk.3,001-5,000	151	50.3	149	49.7	300
Tk.5,001-7,000	55	59.8	37	40.2	92
Tk.7001 or above	95	69.9	41	30.1	136
TOTAL	486	52.4	441	47.6	927
<i>Source of care</i>					
Public facility	28	56.0	22	44.0	50
Private facility	251	58.4	179	41.6	430
UFHP Clinic	171	47.2	191	52.8	362
Other NGOs	19	51.4	18	48.6	37
Others	18	36.7	31	63.3	49
<i>Urban Categories</i>					
Category A	191	53.4	167	46.6	358
Category B	157	52.3	143	47.7	300
Category C	139	51.5	131	47.5	270

Annex Table V-8 shows the average willingness to pay for family planning services by source, economic status of households and urban locations. The table also shows the average willingness to pay for those who paid for service and for those who did not pay for service.

The average willingness to pay for family planning services in the public sector was Tk.12 for those who paid a price and Tk.9.25 for those who did not pay anything for getting family planning services or supplies. The average willingness to pay for the private sector was higher than any other sources, at about Taka 19. The average willingness numbers for NGO service providers were about Taka 13, irrespective of whether the women paid for the service or not. The average willingness for both the private and public sectors increases with greater level of urbanization. The average willingness for public sector service in urban category C was Tk.14 compared to Tk.10 in category A for women who paid for service. The trend is opposite if the women who did not pay for service is considered. In general, it appears that the willingness to pay for family planning declines only slightly if a woman have not paid for the service in the past.

6.4.4 Determinants of Willingness to pay for family planning services

Table 18 reports the regression results to show the relationship between willingness to pay for family planning services and other independent variables. Many variables were considered in the model and the best results are provided here in the table. The equations confirms that knowledge about a free provider or obtaining service for free in the past do not affect the willingness to pay for family planning services. None of these variables were important in any of the equations estimated. Knowledge about the different methods of family planning available was important only in urban category A. Education of the woman (whether the woman has five years of education or not) significantly affect the willingness to pay in all urban regions. On the average, education of the woman increase willingness to pay by Taka 7.00.

Table 18: Effect of Independent Variables on WTP for Family Planning Services

Independent Variables	All locations		Urban location A		Urban location B		Urban location C	
	Coeff	t-value	Coeff	t-value	Coeff	t-value	Coeff	t-value
Knowledge variable	0.963	0.29	9.99	2.05	4.04	0.65	-9.14	-1.64
Education								
GT 5yrs	7.00	5.37	8.13	4.32	5.57	2.29	7.45	3.08
HH Exp	.002	5.76	.0018	3.10	0.003	3.68	0.002	2.86
Constant	6.33	3.06	3.75	1.31	4.00	0.96	10.99	3.01
R-square	0.084		0.128		0.077		0.079	

F-value	34.89	18.26	10.51	10.83
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The models presented in the table also shows strong positive effect of household expenditure on WTP upto an expenditure level of Taka 6,000 per month. The combined regression model suggest that every taka 100 increase in expenditure will increase the willingness to pay by taka 0.2. Therefore, in quantitative terms, the effect of income or expenditures on WTP is relatively low. The only variable that has strong and high impact on willingness to pay is the educational status of the woman.

7.0 COMMUNITY HEALTH WORKER CONTACTS

The Community Health Workers (CHWs) had contacts with about 25% of all households during the past one month in the survey. The proportion of poor households visited by the CHWs was about 27% although they visited about 25% of all households. Therefore, the visit rate to poor households was slightly higher than the visits made to other better-off households. If the total number of households contacted are considered, more than 56% happened in poor households (less than Tk.3,000 expenditure per household) although the poor group represents about 52% of all households. A number of other socio-economic status related variables were used to examine whether the CHWs target the poorer households. The ownership status of house, ownership of land and construction material used in roof construction does not show any significant bias towards the poorer groups.

Among the women who are currently pregnant or women who delivered within 12 months prior to the survey, only 22% mentioned that a community health worker visited their house. Out of the 328 visits, 68% occurred in the households where women know about the importance of obtaining ANC services. More than 72% of women who reported no community health worker visits lacked knowledge about ANC. Although the difference in knowledge between these two groups (had contacts with CHW or did not have contacts with CHW) is not very significant, the visits may have some minor impact on knowledge about ANC.

The distribution of household expenditure levels for those who reported a visit by CHWs was very similar to the overall distribution of expenditure levels. About 45% of all visits occurred in the households with expenditure levels less than Tk.3,000 per month and number of respondents belonging to this group is about 44%.

It is interesting to note that the coverage of CHW visits to the households where the women had no formal education was lower than the next educational category 1-5 years of education. Overall 46% of the women responding to ANC questionnaire reported being illiterate (no education) and 44% of the visits occurred in these households. Only 21% of women with no education were visited by the CHWs. About 29% of CHW visits took place in the households where women had 1-5 years of education. For other educational categories, the coverage of CHW services were proportional to the number of respondents in these categories. Therefore, the CHW visits do not appear to be targeted towards the lower socio-economic category or lower educational status.

The study also examined the relationship between CHW visits and the knowledge of women about various aspects of ANC services. None of these knowledge variables or knowledge index appears to be strongly correlated with the CHW visits. The impact of CHW visits on knowledge about ANC is not significant. Due to high knowledge scores in other types of services, the impact of CHW visits can not be observed from the data. The lack of relationship for ANC indicates that the CHW visits are not very effective in increasing the knowledge base of the women in the locality.

For the households which reported child immunization, the CHW visits again were not targeted towards the poorer socio-economic groups. About 24% of those who reported getting immunization for their children were visited by a CHW. The poorest economic group represents about 44% of all immunization service users and about 49% of CHW visits were to these households. The ratio of percent of household reporting visit and the percent of households poor is more than 1.0, the ratio is not significantly higher to say confidently that the CHWs targeted the poorest group among the immunization users. None of the knowledge variables related to immunization show any statistically significant impact with CHW visits.

From the above analysis, we can say that the CHW visits are not specially targeted towards the households with low income or low educational status of women. The CHW visits are not also related to knowledge and utilization of specific health care services like immunization and ANC services. Women's knowledge about immunization and ANC were not higher than the average if the household was visited by a CHW.

Despite the lack of relationship between CHW visits and knowledge about ANC and child immunization, the CHWs can potentially play an important role in increasing the demand for health care service and the willingness to pay for various health interventions. Knowledge about health care services turned out to be an important variable affecting the willingness to pay. Women from lower socio-economic groups have lower level of knowledge and if the CHW activities are targeted towards them, it will help to increase the utilization of services as well as the willingness to pay for the services.

8.0 CHARACTERISTICS OF NON USERS OF HEALTH SERVICES

The willingness to pay presented in this report are based on the information collected from the users of services. However, an important question is whether the willingness to pay for non-users are similar or not. This question can be addressed in two different ways: first to examine the factors affecting the probability of seeking care. The factors identified can indicate whether price and income play an important role in determining the probability of using the services. The second approach is to examine the differences of specific characteristics between the users and non-users of a service. A number of characteristics of ANC users and non-users are compared in the table below:

Table 19: Characteristics of Users and Non-users of ANC

Characteristics	Percent of users	Percent of non-users
In the HH expenditure group <=3,000	44.1	51.8
In the HH expenditure group 3,001-5,000	30.3	32.4
Education of head <= 5 years		33.8
Education level of head 6-10 years	50.0	49.5
Don't know a clinic where free service is given	71.5	80.2
Know that pregnant mothers should get checkups	92.5	85.0
Don't think that ANC could be harmful	99.5	99.5

Note that a higher proportion of non-users are in the lowest economic status compared to users. More than 92% of users reported that they knew about the need for ANC for pregnant mothers but the proportion was 85% for non-users. Another significant difference between these two groups is about the knowledge of free service provider in the locality. Among the users about 29% knew at least one service provider who provides care free of charge. For non-users, this proportion was 20%. The differences in these proportions are quite small and cannot fully explain why the non-users did not use ANC.

Similar type of comparison between users and non-users are provided below for immunization services. Immunization is a much lower cost service and price or income may not be the most constraining factors.

The proportion of lowest socio-economic category among non-users was only three percent higher than the users. The household head has lower level of education among the non-users compared to the users. In terms of knowledge about immunization, a high proportion from both these groups knew about the benefits. In fact, in terms of knowledge about the benefits, both users and non-users are quite similar. However, non-users are less aware about the details of the benefits one gets from immunization. A greater proportion of those who immunized their children think that failure to immunize their children could also be harmful to other children in the locality. Other variables are more or less similar for both the groups. Again, the differences are not wide enough to explain fully why the non-users did not immunize their children.

Table 20: Characteristics of Users and Non-users of Immunization Services

Characteristics	Percent of users	Percent of non-users
HH expenditure <=Tk.3,000	44.2	47.0
HH expenditure in between 3,001-5000	29.6	29.1
Education of head <=5 years	69.5	77.5
Children should be immunized by age 1	97.5	97.2
Know where to take child for immunization	98.1	95.8
Know the benefits of immunization	98.6	96.8
Can specify the benefits of immunization	80.0	73.7
Think that immunization could be harmful	69.1	61.8
If not immunized, think that it may affect others	41.2	34.4
Know a facility that provides free immunization	56.4	56.1

To understand the use and non-use of ANC by currently pregnant women and women who delivered in last one year, two separate logistic regressions were estimated. The first regression predicts the utilization of ANC by currently pregnant women. The regression equation shows that household economic status is important in predicting the use of ANC. Educational level of women more than five years is also important but price of ANC show no significant impact. Presence of free providers improves utilization rate. Age of woman is not important in explaining the ANC utilization pattern.

For women who delivered in the last one year, all the variables found important for currently pregnant women also turned out to be important here. The predictive power of the model for this group was better than the currently pregnant group. It appears that there is no difference in the pattern of utilization of ANC by these two groups and there is also no age effect implying that among the currently married women, the utilization pattern is similar.

9.0 EXIT INTERVIEW

In total 177 service recipients were interviewed at the exit point visiting six UFHP facilities. The average waiting time for all these service recipients were 16.6 minutes. The waiting time was found to be highest in case of child immunization (27.7 min.). The clients coming for pill and condom supply spend on average about 7 minutes in waiting at the facility for the supply. The average travel cost for them was Tk. 4.23, it was lowest (Tk.2.9) for maternal health. (Table VI-1). The average cost of treatment at the facility

About 70% of the service recipients agreed to pay more than what has been paid for the services. 3% told yes, if quality / behaviour improved (Table VI-2). The average willingness to pay for pill/condom was Tk.25. The willingness to pay maternal health and child health was high, Tk. 30.9 and Tk. 39.5 respectively. For immunization, the average willingness to pay was found to be at Tk. 22.8.

10. WILLINGNESS TO PAY FOR IMPROVED QUALITY OF CARE

This research also asked the respondents (selected for household indepth interviews) about their opinion on the quality of care received from the health centers. The quality of care has been defined using five important attributes: information provided by the care providers, behavior of the providers with patients when providing the care, training and ability of the health care providers, cleanliness of the health centers and waiting time at the health center for receiving the care. All these dimensions of quality of care were asked to the respondents for ANC, immunization, family planning and basic curative services separately.

ANC Service Quality

Annex table VII-1 reports the percent of users who reported that they were very satisfied with the services provided. Among the poor households (with household expenditure below Tk.3,000), 82% reported that the providers gave enough information about ANC when they sought care. Among the highest income group households, 90% reported receiving adequate information. Almost all users reported that they were happy with the behavior of the ANC providers (98.5%). When asked about the quality of ANC checkup received, again 99% reported satisfaction with the service. More than 90% among the poor thought that the health centers where ANC services were provider were quite clean but 86% of the richest group considered the clinics clean. Waiting time was not a problem for 85% of respondents. Among the poor, 82% reported that waiting time was low. The satisfaction with waiting time tends to decline with higher income. It is not clear whether the poorer households actually wait for longer period or they consider similar waiting time as having greater welfare declining impact.

The table also shows the quality of service indicators by urban categories A, B and C. In the most urbanized area, women reported least satisfied with the information they received about ANC from the providers. In urban category A, 36% reported that enough information was not provided but in urban areas B and C the proportion dissatisfied were 5% and 14% respectively. In general, users in category B of urban area clinics appear to be most satisfied. In category B health centers, less than 5% reported that the health centers were not clean and 9% reported that they had to wait a long period of time to obtain services. For categories A and C, dissatisfaction with cleanliness were 17% and 16% and dissatisfaction with waiting time were 12% and 22% respectively.

If the quality indicators are examined by the type of health centers used by the respondents, public sector facilities appear worst in terms of all indicators excepting waiting time. Waiting time was mentioned as a problem by 21% of users of UFHP clinics compared to 12% for the users of public health centers. Table 21 reports the satisfaction indices by the five attributes for ANC users.

Table 21 below summarizes the willingness to pay for ANC if the quality of service is improved. Only very few respondents mentioned that they are willing to pay additional money for the improvements in different quality indicators. Note from the table that waiting time was the most important concern of the women followed by the information provided and cleanliness of the facilities. Among those who were dissatisfied, more than 75% mentioned that they will be willing to pay some additional money to improve the amount of information provided. More than 82% and 76% of unsatisfied clients mentioned that they will pay for improved cleanliness and reduced waiting time respectively. The table also reports the willingness to pay for ANC with and without the quality improvements.

Table 21: Willingness to Pay (WP) for Those who Were not Satisfied with ANC Quality of Care

ANC

Category	Willingness to pay for improvement			Overall average for WP			WP after quality adjustment		
	No	Yes	Total	Mean	Median	Mode	Mean	Median	Mode
Information	33 (23.1)	110 (76.9)	143 (100)	42.1	23.0	5.0	46.3	25.0	10.0
Behavior	4 (44.4)	5 (55.5)	9 (100)	30.2	20.0	5.0	34.1	25.0	25.0
Providers quality	4 (36.4)	7 (63.6)	11 (100)	14.6	15.0	15.0	19.0	15.0	15.0
Cleanliness	16 (17.4)	76 (82.6)	92 (100)	72.4	27.0	15.0	76.0	31.0	20.0
Waiting time	55 (23.1)	183 (76.9)	238 (100)	64.1	30.0	10.0	68.0	35.0	15.0

Quality of Immunization Services

For immunization services, more than 95% mentioned that they were happy with the behavior of the providers and quality of the service received from the health center. Clearly, the satisfaction scores for these two attributes are very high. One reason could be that immunization activities require very little time of the providers and providing immunization in Bangladesh becomes an important social event. It is interesting that provision of enough information, cleanliness of the facilities and waiting time were mentioned as problematic by more than 20% of respondents. About a third of all mothers thought that they did not receive adequate information during the immunization sessions and 18% reported relatively long waiting time. The information provided was considered inadequate by 29% of poor and about 26% of the richest group. Lower-middle income group (Tk.3001-5000) was most dissatisfied in terms of information received, about 39% of the users from this group. Annex table VII-2 reports the satisfaction level of respondents related to immunization services.

If the urban categories are considered, mothers reported highest degree of unhappiness regarding information provision in category A clinics (44%). In category C clinics as well, about a third reported that adequate information was not provided during immunization of children. Waiting time was also reported to be high in category A clinics. If the types of clinics are considered, users of public clinics were relatively more dissatisfied than the UFHP clinics in terms of information provision but UFHP clinics get slightly lower score than public facilities in terms of waiting time.

Table 22 is the summary of the additional amount respondents are willing to pay for improved quality of immunization services. For immunization, the three most important quality concerns are: lack of enough information, long waiting time and cleanliness. The problem of cleanliness is much lower for immunization than for ANC. The proportion of dissatisfied clients willing to pay additional money is found to be quite low for immunization.

Table 22: Willingness to Pay (WP) for Those who Were not Satisfied with Immunization Quality of Care

Immunization

Category	Willingness to pay for improvement			Overall average for WP			WP after quality adjusted		
	No	Yes	Total	Mean	Median	Mode	Mean	Median	Mode
Information	58 (46.8)	66 (53.2)	124 (100)	9.1	7.0	5.0	12.7	10.0	10.0
Behavior	4 (100)	-	4 (100)	7.5	7.5	5.0	10	10.0	10.0
Providers quality	4 (100)	-	4 (100)	10.0	7.5	5.0	13.1	10.0	10.0
Cleanliness	23 (40.4)	34 (59.6)	57 (100)	12.0	10.0	5.0	16.0	15.0	15.0
Waiting time	16 (21.9)	57 (78.1)	73 (100)	12.2	10.0	10	15.6	15.0	15.0

Quality of Family Planning services

For family planning services as well, almost all women were satisfied with the behavior of the provider. They also thought that the providers were 'good' and qualified. However, 74% of women from the poorest expenditure class and 86% from the highest expenditure class considered that the information provided about family planning was adequate. Higher expenditure groups appear to be less happy in terms of cleanliness of the facility. The highest economic group was also most happy in terms of waiting time at the center for obtaining the services.

The women in urban category B were more happy than women in other urban areas in terms of information provided, behavior of the provider, quality of the provider, and cleanliness of facilities. In metropolitan areas (category A), about 48% of users of family planning services felt that enough information was not provided to them by the providers.

When we examine the proportions of women satisfied with the quality of service, it is important to note that UFHP facilities get high rank in perceived quality measures. In fact, women using family planning services considered UFHP clinics better than the private clinics in all areas excepting the category 'information provided'. In this category, 74% of UFHP users were satisfied compared to 76% for private clinics and 77% for public clinics. Waiting time was also reported to be low by about 93% women using UFHP clinics. Annex table VII-3 reports the satisfaction of women with the quality of family planning services.

For family planning services as well the three most important quality concerns are inadequate provision of information about the service, cleanliness of the facilities and long waiting time. In general, inadequate information concerns many more women than any other quality indicators we have used. A number of these unhappy clients were also willing to pay additional money for improving some specific aspects of service provision. If the health care delivery system can improve the amount of relevant information provided to women, improve the cleanliness of the facilities and reduce waiting time, more than 20% of all women will be willing to pay additional Tk.4 to 10 taka for family planning services. Table 23 reports these numbers.

Table 23: Willingness to Pay (WP) for Those who Were not Satisfied with Family Planning Quality of Care

Category	Family Planning								
	Willingness to pay for improvement			Overall average for WP			WP after quality adjusted		
	No Exp	Yes Exp	Total	Mean	Median	Mode	Mean	Median	Mode

Information	37 (22.7)	126 (77.3)	163 (100)	11.6	10.0	15.0	15.2	15.0	20.0
Behavior	4 (44.4)	5 (55.6)	9 (100)	14.3	11.0	15.0	16.8	16.0	10.0
Providers quality	12 (70.6)	5 (29.4)	17 (100)	9.5	5.0	5.0	13.2	10.0	10.0
Cleanliness	11 (21.2)	41 (78.8)	52 (100)	12.9	11.5	15.0	16.8	15.5	20.0
Waiting time	23 (37.7)	38 (62.3)	61 (100)	14.2	10.0	15.0	17.4	15.0	15.0

Quality of basic curative service provided

Annex table VII-4 shows the proportion of respondents satisfied with the quality of service of curative care. Again, in general, respondents were quite happy with the quality of curative care provided by different facilities. Almost all respondents mentioned that the behavior of the medical care providers was good, the providers were very qualified and the facilities were clean. About 25% of the women thought that the waiting time for curative care was relatively long and 20% reported that they were not provided enough information by the medical care providers about the illnesses. The satisfaction levels were almost identical among all the economic groups.

Women in urban area A were most unhappy about the level of information provided. In fact, 38% of the respondents in urban category A were not happy with the amount of information given in case of an illness. Waiting time was reported to be a problem more by the respondents in urban area B than in other urban areas.

Public facilities were considered relatively bad in terms of information provision about illness and waiting time. The UFHP was rated at least as good as the private providers in terms of all the quality indicators used here.

Table 24 shows the number of respondents reporting dissatisfaction with the quality of care provided for illness conditions. For illness cases, lack of information and waiting time both becomes equally important.

Table 24: Willingness to Pay (WP) for Those who Were not Satisfied with Illness Quality of Care

Category	Willingness to pay for improvement			Overall average for WP			WP after quality adjusted		
	No Exp	Yes Exp	Total	Mean	Median	Mode	Mean	Median	Mode
Information	14 (9.3)	137 (90.7)	151 (100)	99.7	60.0	20.0	103.7	65.0	210.0
Behavior	3 (12.5)	21 (87.5)	24 (100)	198.1	90.0	20.0	199.6	91.3	20.0
Providers quality	2 (8.7)	21 (91.3)	23 (100)	166.2	62.0	20.0	168.7	64.5	22.5
Cleanliness	17 (15.7)	91 (84.3)	108 (100)	90.0	60.0	155.0	93.8	65.0	160.0
Waiting time	22 (14.7)	128 (85.3)	150 (100)	127.6	62.5	10.0	131.6	65.0	25.0

11. COMPARISON OF UFHP AND ANOTHER NGO CLINIC

The areas where comparison between NGOs were made were in category A and C. The other NGO was also found to be providing ESP services in these areas. It was found that these NGO had field workers to provide doorstep services. The NGO found in Category A area provided MR services. The UFHP clinics were found to be more equipped with IEC materials and staffing pattern also differ from others. The comparison of registration fee in the UFHP and other NGO facilities are given at Table: VIII-1 to VIII-4 gives the detail. The registration fee at one of the other NGO was found to be higher than in UFHP NGO.

Among the different family planning services, UFHP clinic in urban category A did not provide four specific services while the other NGO did not provide three. The UFHP clinic in urban category C provides all the family planning services provided in urban clinic category A but the NGO clinic in urban category C was found to be very basic. The NGO clinic in urban area C provided only two of nine different family planning services. In reproductive health area, UFHP clinic provided less number of lines of services than other NGO clinic in urban area A. For child health and laboratory services, UFHP and other NGO clinics in urban location A are almost similar in terms of different types of services available. In urban area C, UFHP clinic provide higher number of types of services than the NGO clinic.

Therefore, the UFHP clinics generally provide wide range of family planning, reproductive health, child health and laboratory services and it should be quite competitive in the market in terms of different lines of activities organized and provided. In urban category C, the UFHP clinics appear to be much better in terms of number of different types of services provided.

Price set at the median level	91.6	47.0	9.3	1.1	-	24.9
Price set at modal value	47.0	5.3	0.8	-	-	3.7

The results can be simulated by using any other price levels. If the major objective of the UFHP is cost recovery, the cost of production data can be used as the price to see whether most of the households in the UFHP areas will be able to pay for the service package. A computer program has been written to carry out these simulations and the HEP can perform the calculations for the alternative price scenarios if requested by the policy makers or UFHP managers.

As noted earlier, the study households are selected in a way where households with pregnant mothers, or children, or mothers eligible for family planning are mainly selected. Under such circumstances, the sample either over or under-represent different demographic groups as compared to national estimates or our estimates from the census survey (see annex table ...). If we have to make estimates of the proportion of population who are not able to pay for the package by considering the community as whole, it will be necessary to correct the estimated value for the packages with correction factor that are shown in annex table ???.

One additional useful analysis could be to consider few hypothetical demographic characteristics of households to estimate their health care expenditure based on the need definition mentioned above. Three different hypothetical household expenditure groups (as a proxy of income) with five different demographic structures were considered to examine the ability to pay. In other words, this exercise determines whether a household belonging to a specific expenditure group (Tk. 2000, Tk.4000, and Tk. 6000) can afford to pay for a set of very basic health care services. For each of these household categories, total health care expenditure has been calculated using modal values (using the survey data for different type of care) and shown as portion of their total household expenditure. The five hypothetical demographic characteristics of household that were considered are as follows:

HH1: One adult male, one adult female (the couple is family planning user), four under five children. This type of household's health care need include one illness care for each adult person in a year, family planning services over the year, two illness episode for each child and immunization services for each child.

HH2: One adult male, one pregnant woman, four under five children. This type of household will need 3 visits for ANC, and immunization services for two children, two illness care for them in a year, and two illnesses care for other two children.

HH3: One adult male, one adult woman (using family planning), one child above 5 year, and 3 under five children. In this household, the total demand for health services include, two illnesses care for the adults person, family planning services, one illness care for children, and six illness care for three children and two visits for immunization visits.

HH4: One adult male, one pregnant woman, one child above 5 years, three under five children. This family will need illness care for adults, ANC, child illness care visits, and six child illness care, and one immunization visits.

HH5: One adult male, one adult female (using family planning services), two children, above 5, two under five children. This type of family needs one adult illness care, one family planning services, four child health care need two immunization services through immunization.

Table 25 shows the health care expenditure (using modal value) as a proportion of total household expenditure (income) of five different demographic structures. The value higher than 1.5 shows that the household will not be able to pay for the services required as a basic health care package.

Table 26: Health Care Expenditure for the Basic Health Care as a Proportion of the Total Household Expenditure Levels (Taka)

HH Structure	1500	3000	5000	7000
HH1	1.95	0.97	0.58	0.42
HH2	1.72	0.86	0.52	0.37
HH3	2.00	1.00	0.60	0.43
HH4	1.78	0.89	0.53	0.38
HH5	2.06	1.03	0.62	0.44

Note that, households earning Tk.1,500 per month will not be able to pay whatever be their demographic composition. Household expenditure level of Tk.3,000 or more should be able to pay for the basic health care services considered here. In fact, household expenditure level of Tk.2,000 becomes marginally not able to pay for the basic package of service. Therefore, if the health care system is planning to develop a mechanism of 'safety net' for the disadvantaged groups, one criterion could be to use the expenditure level of Tk.2,000 or less. Using expenditure levels as targeting criterion is extremely difficult and often not practical. Further analyses should be carried out to identify a number of easily observable indicators, which can be used to identify the target group. This exercise indicates that about 15 to 17 percent of households should be considered by the health care delivery system for some type of price subsidy.

13. CONCLUSIONS AND POLICY IMPLICATIONS

The study examined the health seeking behavior, willingness and ability to pay for selective health care services in urban Bangladesh. Using the UFHP definition of urban categories, the survey was carried out in all the three urban areas: A, B and C.

It should be noted here that the study examines the health seeking, willingness and ability to pay for a specific target group, the households with women in reproductive age group. In selecting the sample, households with pregnant woman and women delivered during the last one year were emphasized. Therefore, the results of this analysis apply to these specific target groups. The types of services provided by UFHP implicitly target these groups and therefore, the analysis will be useful for understanding the utilization of UFHP provided services and the willingness and ability to pay of those households who are more likely to use the UFHP facilities.

The survey of this research was carried out in the immediate geographic area around the UFHP health centers. Comparison of the average economic status of households around the static clinics and satellite clinics indicates that the population around the satellite clinics are much poorer than the households around the static clinics. Clearly, operation of satellite clinics significantly improves the access of the poor to UFHP clinics. This also indicates that UFHP is quite successful in locating the satellite clinics in areas to improve the access of extremely poor households to the clinic services.

The study examined a number of specific health care services for more in-depth analysis. The health services considered here are: Antenatal Care, Immunization, Family planning and basic curative services.

The survey found that most women are aware of the benefits of ANC. Although more than 95% of women reported that ANC services are needed for pregnant women, 13% of women in urban area C (the least

urbanized area) did not know the importance of ANC. Therefore, it is important to strengthen the health education aspects in urban area C. The survey also indicates that the women are not fully aware of the benefits of ANC. Efforts should be directed towards improving the depth of knowledge in all urban areas of the country.

Knowledge about availability of ANC providers was also found to be quite good among the women. In urban area C, slightly higher proportion of women were not aware compared to the proportions in other two areas. In urban location C, only 29% of women mentioned UFHP clinics as a source of ANC. Since the survey households are located very close to the UFHP clinics, it is quite surprising that so many failed to mention UFHP clinics. In urban category C, UFHP should try to improve the visibility of their clinics and take appropriate actions to better market the services provided through their clinics.

Most of the women were aware of the market price of ANC services. Minimum market prices of ANC reported by women vary from about Taka 20 to 60. Less than 20% of women consider UFHP price for ANC as high. This should be the upper limit of the proportion of households not able to pay for ANC services.

The comparison of the utilization patterns of public and UFHP clinics for currently pregnant women and women who delivered in the last one year indicates an interesting trend. The utilization patterns show that the UFHP clinics have become relatively more important for ANC services for currently pregnant women compared to the relative utilization rate for women who delivered in the last one year. Therefore, over the last one-year period, women are using the UFHP clinics more frequently than they used in the past. The relative increase in the utilization of UFHP clinics has occurred at the expense of public facilities. In other words, the UFHP clinics are competing with the public sector facilities for the delivery of ANC.

The ANC service is relatively expensive (per unit cost) but still price paid for ANC was not very significant in explaining utilization or non-utilization of ANC services. Household income, education level of the woman and knowledge of woman about the benefits of ANC appear much more important in determining the demand for ANC.

For the immunization activities, the survey found that women had almost perfect information about immunization. So, knowledge was not a problem for immunization. Despite the perfect knowledge only 69% of the children were immunized. Important sources of immunization were public facilities and UFHP clinics. Therefore, knowledge has not been transformed into action in Bangladesh urban areas. It is important to examine why so many households fail to immunize their children even though they are fully aware about the benefits of immunization.

In urban areas, about 50% of mothers reported obtaining immunization free of cost. Access to free immunization is similar for all socioeconomic groups. Access to free immunization may be important for increasing the coverage of immunization. However, it is not clear how important is access to free service for seeking immunization for children. Further analyses are needed to find out the effect of price and free care on the utilization of immunization by various socioeconomic groups. It is possible that for poor households availability of free immunization is important. Since about half of the respondents paid some money for immunization, equity in the delivery of immunization can be improved by better targeting the free provision towards the poorer households.

About 17% of women who paid for immunization mentioned that the fee for immunization was too high. If we consider the households who did not pay anything for immunization as belonging to this group, total proportion of women considering the current charges too high should be about 58%. About 62% of mothers who paid for immunization mentioned that they are willing to pay more money than what they have paid last time, if needed. Therefore, about 30% of households with young children are willing to pay more than what they have already paid last time.

It appears that imposing fee on immunization may adversely affect the utilization of immunization services. Since the coverage of immunization is quite low, it is important to strengthen delivery of immunization services in urban areas. The UFHP clinics are already playing very important role in the delivery of

immunization along with the public sector. The efforts of public sector and UFHP should be closely coordinated to improve the delivery of immunization services.

For the curative care services, households living in the UFHP clinic areas do not consider the clinics as the providers of basic curative services. Only 14% of respondents mentioned UFHP clinics as a source of ARI care services. For diarrhoea, only 8.5% mentioned UFHP clinics as source. Households in the UFHP clinic areas consider the clinics as providing maternal and child care preventive services. The marketing strategy of UFHP should also emphasize the availability of curative services.

About 60% of women obtained family planning services from the public sector and the UFHP clinics. The remaining 40% obtained the services from the private sector. Willingness to pay for family planning services is dependent upon educational level of women and household economic status. Knowledge about family planning services was not important in determining the willingness to pay.

During the past one month (prior to the survey), a significant number of households were visited by a community health workers. It should be noted that all the community health worker visits may not be from the UFHP facilities. The study did not find any correlation between the CHW visits and the knowledge and practice of the households. This does not necessarily imply that the CHWs are not effective. It is possible that the positive effects of CHW visits are not observable due to their visits to other households in the previous months. If the CHW visits have any positive impact, visits to all or almost all households over four to five month period may reduce variability among households. However, the survey did not ask about the visit of CHWs over the last four to five months and it was not possible to estimate the effect of CHW visits.

Comparison of users and non-users of different services indicate that slightly higher number of non-users of ANC were from the poor household category. Non-users also differ significantly in terms of their knowledge of a facility that provides free ANC service. Other than these two variables, the users and non-users of ANC are very similar. Knowledge and household economic status show some minor impact on immunization rates. Again, the users and non-users of immunization were not significantly different in terms of other variables. It appears that the change of status from non-user to user requires considerable efforts from the providers. Better education and knowledge improves the willingness to pay for services but do not show significant impact on utilization.

A simple exercise was carried out to understand the ability of pay of households for basic medical care services including family planning and preventive care. If the median price is used, about 23% of households will not be able to pay for the basic package defined. If the modal price is used, less than four percent of households will not be able to pay. In general, the analysis indicates that Tk.2,000 of expenditure per household per month should be used as the cut-off level to define inability to pay for the basic package. If this definition is used, 14 to 17% of households will require price subsidy.

The survey shows that the average minimum price in the market reported by women for various services were higher than the price charged by UFHP clinics. Therefore, the fee structure of UFHP is not higher than the minimum price of the service in the market. This does not necessarily mean that UFHP should raise the price. As a responsible social organization, UFHP should carefully examine the impact of the prices on utilization and final outcome.

Even if the average willingness to pay numbers are used for various health care services, the amount of payment per service remains so low that it is unlikely to recover more than 50% of the cost. Since, implementing a perfectly designed sliding scale (i.e., prices charged is same as the willingness to pay) is impossible, the cost recovery ratio in the short-run is unlikely to exceed 30% level. Given the fact that health care services from UFHP clinics will remain quite heavily subsidized, the policy makers should examine differential subsidy levels for different types of services to improve total social well-being of the population.

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ANNEX I

BASIC HOUSEHOLD INFORMATION**Table I-1 : Age distribution of the household members in the UFHP clinic areas**

Age Group	Static Clinic Areas				Satellite Clinic Areas					
	N	Male %	N	Female %	Total	N	Male %	N	Female %	Total
< 1 yr	92	5.8	80	4.8	172	381	6.0	427	6.8	808
1-2 yr	127	8.0	112	6.7	239	486	7.7	462	7.3	948
3-4 yr	98	6.2	142	8.5	240	525	8.3	472	7.5	997
5-10 yr	216	13.6	224	13.3	440	930	4.7	996	15.8	1926
11-14 yr	82	5.2	120	7.1	202	467	7.4	445	7.0	912
15-19 yr	85	5.3	148	8.8	233	354	5.6	741	11.7	1095
20-24 yr	83	5.2	253	15.1	336	338	5.3	832	13.2	1170
25-29 yr	156	9.8	212	12.6	368	580	9.1	684	10.8	1264
30-34 yr	212	13.3	130	7.7	342	696	11.0	399	6.3	1095
35-49 yr	341	21.4	89	5.3	430	1141	8.0	360	5.7	1501
50+	98	6.2	169	10.1	267	443	7.0	499	7.9	942
Total	1590	100	1679	100	3269	6341	100	6317	100	12658

ANNEX I

**BASIC HOUSEHOLD INFORMATION
CATEGORY A**

Table I-2: Age distribution of household members in the UFHP clinic areas

Age Group	Static Clinic Areas				Satellite Clinic Areas					
	N	Male %	N	Female %	Total	N	Male %	N	Female %	Total
<1 yr	18	3.9	22	4.3	40	109	5.5	137	6.9	246
1-2 yr	42	9.1	41	8.1	83	145	7.3	156	7.9	301
3-4 yr	33	7.1	46	9.1	79	163	8.2	159	8.1	322
5-10 yr	70	15.2	65	12.8	135	317	16.0	312	15.8	629
11-14 yr	26	5.6	38	7.5	64	156	7.9	147	7.4	303
14-19 yr	26	5.6	35	6.9	61	120	6.1	241	12.2	361
20-24 yr	14	3.0	76	15.0	90	108	5.4	270	13.7	378
25-29 yr	46	10.0	68	13.4	114	195	9.8	204	10.3	399
30-34 yr	66	14.3	44	8.7	110	208	10.5	124	6.3	332
35-49 yr	100	21.6	30	5.9	130	350	17.7	113	5.7	463
50+ yr	21	4.5	43	8.5	64	111	5.6	111	5.6	222
Total	462	100.00	508	100.0	970	1982	100.0	1974	100.0	3956

ANNEX I

BASIC HOUSEHOLD INFORMATION

CATEGORY B

Table I-3: Age distribution of household members in the UFHP clinic areas

Age Group	Static Clinic Area					Satellite Clinic Area				
	Male		Female		Total	Male		Female		Total
	N	%	N	%		N	%	N	%	
<1 yr	39	8.3	19	3.9	58	102	6.2	129	7.7	231
1-2 yr	27	5.8	34	6.9	61	137	8.3	112	6.7	249
3-4 yr	31	6.6	40	8.1	71	138	8.3	116	6.9	254
5-10 yr	51	10.9	63	12.8	114	217	13.1	239	14.2	456
11-14 yr	25	5.3	38	7.7	63	115	6.9	108	6.4	223
15-19 yr	26	5.6	48	9.8	74	84	5.1	189	11.3	273
20-24 yr	31	6.6	76	15.4	107	88	5.3	242	14.4	330
25-29 yr	50	10.7	60	12.2	110	123	7.4	206	12.3	329
30-34 yr	53	11.3	35	7.1	88	216	13.0	110	6.6	326
35-49 yr	98	20.9	22	4.5	120	327	19.7	90	5.4	417
50+ yr	37	7.9	57	11.6	94	109	6.6	138	8.2	247
Total	468	100.0	492	100.0	960	1656	100.0	1679	100.0	3335

ANNEX I

BASIC HOUSEHOLD INFORMATION CATEGORY C

Table I-4: Age distribution of household members in the UFHP clinic areas

Age Group	Satatic Clinic Areas				Satellite Clinic Areas					
	Male		Female		Total	Male		Female		Total
	N	%	N	%		N	%	N	%	
<1 yr	35	5.3	39	5.7	74	170	6.3	161	6.0	331
1-2 yr	58	8.8	37	5.4	95	204	7.5	194	7.3	398
3-4 yr	34	5.2	56	8.2	90	224	8.3	197	7.4	421
5-10 yr	95	14.4	96	14.1	191	396	14.7	445	16.7	841
11-14 yr	31	4.7	44	6.5	75	196	7.3	190	7.1	386
14-19 yr	33	5.0	65	9.6	98	150	5.5	311	11.7	461
20-24 yr	38	5.8	101	14.9	139	142	5.3	320	12.0	462
25-29 yr	60	9.1	84	12.4	144	262	9.7	274	10.3	536
30-34 yr	93	14.1	51	7.5	144	272	10.1	165	6.2	437
35-49 yr	143	21.7	37	5.4	180	464	17.2	157	5.9	621
50+ yr	40	6.1	69	10.2	109	223	8.3	250	9.4	473
Total	660	100.0	679	100.0	1339	2703	100.0	2664	100.0	5367

ANNEX I

Table I-5 : years of schooling of the head of the households suveyed in the UFHP areas

Years of schooling	Static Clinic Area (N=600)				Satelite Clinic Area (N=2404)			
	Female		Male		Female		Male	
	N	%	N	%	N	%	N	%
0 yr	4	22.2	106	18.2	16	55.2	1131	47.6
1 – 5 yr	6	33.3	111	19.1	5	17.2	498	21.0
6 – 10 yr	7	33.9	172	29.6	6	20.7	527	22.2
11 or more yr	-	-	188	32.3	2	6.9	134	5.6
Do not know	1	5.6	5	.9	-	-	85	3.6
Total	18	100.00	582	100.00	29	100.00	2375	100.00

ANNEX I

Table I-6 : years of schooling of the head of the households by UFHP Urban categories

Years of schooling	Category A		Category B		Category C	
	N	%	N	%	N	%
0 yr	388	40.8	264	31.1	605	50.2
1 – 5 yr	197	20.7	192	22.6	231	19.2
6 – 10 yr	226	23.8	247	29.1	239	19.8
11 or more yr	106	11.1	117	13.8	101	8.4
Do not know	34	3.6	28	3.3	29	2.4
Total	951	100.00	848	100.0	1205	100.0

Table I-7 : years of schooling of the head of the households by UFHP Urban categories

Years of schooling	Category A				Category B				Category C			
	Static		Satelite		Static		Satelite		Static		Satelite	
	N	%	N	%	N	%	N	%	N	%	N	%
0 yr	31	17.4	357	46.2	32	17.7	232	34.8	47	19.5	558	57.9
1 – 5 yr	30	16.9	167	21.6	40	22.1	152	22.8	47	19.5	184	19.1
6 – 10 yr	43	24.2	183	23.7	60	33.1	187	28.0	76	31.5	163	16.9
11 or more yr	73	41.0	33	4.3	44	24.3	73	10.9	71	29.5	30	3.1
Do not know	1	.6	33	4.3	5	2.8	23	3.4	-	-	29	3.0
Total	178	100.0	773	100.0	181	100.0	667	100.0	241	100.0	964	100.0

ANNEX I

Table 1-8: Percentage distribution of households into household expenditure groups by UFHP areas

HH Expenditure Group (taka per month)	All categories (N=3004)		Category A (N=951)		Category B (N=848)		Category C (N=1205)	
	Static Area (N=600)	Satellite Area (N=2404)	Static Area (N=178)	Satellite Area (N=773)	Static Area (N=181)	Satellite Area (N=667)	Static Area (N=241)	Satellite Area (N=964)
<=3000	32.5	56.6	28.7	53.3	36.5	54.4	32.4	60.7
3001-5000	24.7	28.6	21.3	33.8	26	28.9	26.1	24.2
5001-7000	15	9.3	16.3	9.1	14.4	10.2	14.5	8.8
7000+	27.8	5.6	33.7	3.9	23.2	6.4	27	6.3
All groups total HH(N)	100	100	100	100	100	100	100	100

ANNEX II

Table II-1: Women’s knowledge about the need for ANC and opinion about the number of ANC visit

	TOTAL	Need for ANC		Number of times ANC visits should be made				
		“No”	“Yes”	3-5 times	6-10 times	When needed	Other	Don’t know
Urban Categories								
A	980 (100.0)	19 (1.9)	961 (98.1)	268 (27.9)	320 (33.3)	81 (8.4)	54 (5.6)	238 (24.8)
B	887 (100.00)	30 (3.4)	857 (96.6)	242 (28.2)	257 (30.0)	78 (9.1)	74 (8.6)	206 (24.0)
C	1281 (100.0)	157 (12.3)	1124 (87.7)	352 (31.3)	290 (25.8)	53 (4.7)	134 (11.9)	295 (26.2)
<i>Total (all categories)</i>	<i>3148 (100.0)</i>	<i>206 (6.5)</i>	<i>2942 (93.5)</i>	<i>862 (29.3)</i>	<i>867 (29.5)</i>	<i>212 (7.2)</i>	<i>262 (8.9)</i>	<i>739 (25.1)</i>
HH Expenditure Level (taka per month)								
<=3000	1565 (100.0)	113 (7.2)	1452 (92.8)	437 (30.1)	321 (22.1)	89 (6.1)	158 (10.9)	447 (30.8)
3001-5000	879 (100.0)	57 (6.5)	822 (93.5)	242 (29.4)	249 (30.3)	79 (9.6)	54 (6.6)	198 (24.1)
5001-7000	341 (100.0)	20 (5.9)	321 (94.1)	108 (33.6)	114 (35.5)	21 (6.5)	26 (8.1)	52 (16.2)
>7000	363 (100.0)	16 (4.4)	347 (95.6)	75 (21.6)	183 (52.7)	23 (6.6)	24 (6.9)	42 (12.1)
Total	<i>3148 (100.0)</i>	<i>206 (6.5)</i>	<i>2942 (93.5)</i>	<i>862 (29.3)</i>	<i>867 (29.5)</i>	<i>212 (7.2)</i>	<i>262 (8.9)</i>	<i>739 (25.1)</i>

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Table II-2: Women’s knowledge about the benefits of ANC visit

	TOTAL	Any benefit of ANC?		Reported benefits of using ANC services				
		“No”	“Yes”	<i>Helps to identify mothers’ physical problem</i>	<i>Helps to identify children’s physical problem</i>	<i>Position of the baby can be known</i>	<i>Possible to prevent complexities during delivery</i>	<i>Others</i>
Urban Categories								
A	980 (100.0)	39 (4.0)	941 (96.0)	571 (60.7)	276 (29.3)	494 (52.5)	216 (23.0)	226 (24.0)
B	887 (100.0)	63 (7.1)	824 (92.9)	384 (46.6)	284 (34.5)	516 (62.6)	60 (7.3)	293 (35.6)
C	1281 (100.0)	172 (13.4)	1109 (86.6)	612 (55.2)	362 (32.6)	512 (46.2)	84 (7.6)	332 (29.9)
<i>Total (all categories)</i>	<i>3148 (100.0)</i>	<i>274 (8.7)</i>	<i>2874 (91.3)</i>	<i>1567 (54.5)</i>	<i>922 (32.1)</i>	<i>1522 (53.0)</i>	<i>360 (12.5)</i>	<i>851 (29.6)</i>
<i>HH Expenditure Level (taka per month)</i>								
<=3000	1565 (100.0)	159 (10.2)	1406 (89.8)	728 (51.8)	419 (29.8)	701 (49.9)	154 (11.0)	408 (29.0)
3001-5000	879 (100.0)	75 (8.5)	804 (91.5)	450 (56.0)	246 (30.6)	425 (52.9)	108 (13.4)	241 (30.0)
5001-7000	341 (100.0)	26 (7.6)	315 (92.4)	173 (54.9)	110 (34.9)	193 (61.3)	45 (14.3)	103 (32.7)
>7000	363 (100.0)	14 (5.1)	349 (96.1)	216 (61.9)	147 (42.1)	203 (58.2)	53 (15.2)	99 (28.4)
Total	<i>3148 (100.0)</i>	<i>274 (8.7)</i>	<i>2874 (91.3)</i>	<i>1567 (54.5)</i>	<i>922 (32.1)</i>	<i>1522 (53.0)</i>	<i>360 (12.5)</i>	<i>851 (29.6)</i>

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Table II-3: Women’s knowledge about possible sources of ANC in UFHP areas by type of providers

	TOTAL	Know an ANC provider		Reported ANC providers in the area			
		“No”	“Yes”	<i>Public</i>	<i>Private</i>	<i>UFHP</i>	<i>Other NGO</i>
Urban Categories				<i>(percent of women mentioning a source in parentheses)</i>			
A	980 (100.0)	70 (7.1)	910 (92.9)	562 (61.8)	235 (25.8)	562 (61.80)	7 (0.8)
B	887 (100.0)	54 (6.1)	833 (93.9)	689 (82.7)	222 (26.7)	320 (38.4)	3 (0.4)
C	1281 (100.0)	134 (10.5)	1147 (89.5)	1044 (91.0)	349 (30.4)	331 (28.9)	2 (0.2)
<i>Total (all categories)</i>	<i>3148 (100.0)</i>	<i>258 (8.2)</i>	<i>2890 (91.8)</i>	<i>2295 (79.4)</i>	<i>806 (27.9)</i>	<i>1213 (42.0)</i>	<i>12 (0.4)</i>
HH Expenditure Level (taka per month)							
<=3000	1565 (100.0)	257 (10.0)	1408 (90.0)	1083 (76.9)	382 (27.1)	661 (46.90)	8 (0.6)
3001-5000	879 (100.0)	67 (7.6)	812 (92.4)	630 (77.6)	209 (25.7)	371 (45.7)	4 (0.5)
5001-7000	341 (100.0)	22 (6.5)	319 (93.5)	279 (87.5)	96 (30.1)	93 (29.2)	-
>7000	363 (100.0)	12 (3.3)	351 (96.7)	303 (86.3)	119 (33.9)	88 (25.1)	-
Total	<i>3148 (100.0)</i>	<i>258 (8.2)</i>	<i>2890 (91.8)</i>	<i>2295 (79.4)</i>	<i>806 (27.9)</i>	<i>1213 (42.0)</i>	<i>12 (0.4)</i>

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Table II - 4: Women’s knowledge about ANC providers who do not charge any money in UFHP areas

Urban Categories	Know an provider which is free?		“Don’t know”	TOTAL
	“Yes”	“No”		
A	126 (12.9)	582 (59.4)	272 (27.8)	980 (100.0)
B	241 (27.2)	394 (44.4)	252 (28.4)	887 (100.0)
C	591 (46.1)	324 (25.3)	366 (28.6)	1281 (100.0)
<i>Total (all categories)</i>	958 (30.4)	1300 (41.3)	890 (28.3)	3148 (100.0)

Table II - 5: Women’s knowledge about ANC providers charging money in UFHP areas and by socio-economic group

	Know a provider and the provider name			“No”	“Don’t know”	TOTAL (N)
	Only UFHP	Both	Only others			
<i>Urban Categories</i>						
A	181 (22.02)	278 (33.82)	363 (44.16)	27 (2.8)	131 (13.4)	980 (100.0)
B	148 (20.93)	133 (18.81)	426 (60.25)	25 (2.8)	155 (17.5)	887 (100.0)
C	289 (33.64)	167 (19.44)	403 (46.92)	71 (5.5)	351 (27.4)	1281 (100.0)
<i>Total (all categories)</i>	618 (25.88)	578 (24.20)	1192 (49.92)	123 (3.9)	637 (20.2)	3148 (100.0)
<i>HH Expenditure Level (taka per month)</i>						
<=3000	337 (29.98)	276 (24.56)	511 (45.46)	76 (4.9)	365 (23.3)	1565 (100.0)
3001-5000	163 (24.29)	177 (26.38)	331 (49.33)	30 (3.4)	178 (20.3)	879 (100.0)
5001-7000	52 (18.64)	65 (23.30)	162 (58.06)	9 (2.6)	53 (15.5)	341 (100.0)
>7000	66 (21.02)	60 (19.11)	182 (59.87)	8 (2.2)	41 (11.3)	363 (100.0)
<i>Total</i>	618 (25.88)	578 (24.20)	1192 (49.92)	123 (3.9)	637 (20.2)	3148 (100.0)

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Table II - 6: Women’s knowledge about the service charges for ANC services in UFHP areas

	Average of maximum fee mentioned		Average of minimum fee mentioned		Average of UFHP price		UFHP price							
	N	Avg.	N	Avg	N	Avg	High		Low		Ok		Total	
<i>Urban Category</i>	N	Avg.	N	Avg	N	Avg	N	%	N	%	N	%	N	%
A	691	38.49	691	24.71	378	15.92	66	17.5	65	17.2	247	65.3	378	100
B	654	51.77	654	33.19	233	16.34	52	22.3	39	16.7	142	60.9	233	100
C	738	51.58	740	31.95	399	10.92	60	15.0	74	18.5	265	66.4	399	100
Total	2083	47.30	2085	29.94	1010	14.04	178	17.6	178	17.6	654	64.8	1010	100
<i>Socio-economic group</i>	N	Avg.	N	Avg	N	Avg	N	%	N	%	N	%	N	%
Less than 3000	979	30.41	980	20.26	526	12.44	109	20.7	83	15.8	334	63.5	526	100
3001-5000	587	46.73	588	29.78	287	14.89	47	16.4	46	16.0	194	67.6	287	100
5001-7000	253	68.89	253	42.60	96	17.18	13	13.5	19	19.8	64	66.7	96	100
Above 7000	264	90.50	264	54.08	101	16.98	9	8.9	30	29.7	62	61.4	101	100
Total	2083	47.30	2085	29.94	1010	14.04	178	17.6	178	17.6	654	64.8	1010	100

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Table II - 7: Visit for ANC by different categories

Urban Categories	Women delivered in last one year		Women currently pregnant	
	No.	Percentage seeking ANC	No.	Percentage seeking ANC
A	267	61.0	161	51.6
B	289	69.6	154	55.2
C	389	58.9	281	46.6
Total	945	62.8	596	50.2

Table II - 8: Source of ANC for respondents (delivered in last one year) in UFHP areas*

Urban Categories	Public Sector		Private Sector		UFHP		Other NGO	
	N	%**	N	%	N	%	N	%
A (N=83)	49	30.2	26	16.0	51	31.5	35	21.6
B(N=85)	71	35.5	70	35.0	34	17.0	24	12.0
C(N=131)	83	36.4	65	28.5	70	30.7	9	3.9
Total(N=299)	203	34.4	161	27.3	155	26.3	68	11.5

* The residual category of providers “others” has been excluded from the table

** Row percent; percent values do not add up to 100 due to “others”

Table II - 9: Source of ANC for respondents (currently pregnant) in UFHP areas

Urban Categories	Public Sector		Private Sector		UFHP		Other NGO	
	N	%	N	%	N	%	N	%
A(N=162)	15	18.1	13	15.7	32	38.6	22	26.5
B(N=200)	23	27.1	26	30.6	25	29.4	11	12.9
C(N=228)	47	35.9	33	25.2	48	36.6	3	2.3
Total(N=590)	85	28.4	72	24.1	105	35.1	36	12.0

Table II-10: Reasons for selecting the providers used for ANC services

Reasons	Public Sector		Private		UFHP		Other NGO	
	N	%	N	%	N	%	N	%
Near the house	77	14.1	54	12.0	170	32.4	36	17.4
Free service/Free Drugs	162	29.6	20	4.4	50	9.5	22	10.6
Convenient Time	91	16.6	85	18.8	69	13.2	39	18.8
Drugs Available	-	-	1	.2	3	.6	-	-
Less Waiting time	2	.4	3	.7	11	2.1	-	-
Clean Facility	4	.7	8	1.8	21	4.0	9	4.3
Qualified provider	94	17.2	170	37.7	52	9.9	34	16.4
Female provider	22	4.0	44	9.8	59	11.3	11	5.3
Well behaved provider	18	3.3	31	6.9	29	5.5	10	4.8
Others	77	14.1	35	7.8	60	11.5	46	22.2
Total	547	100.0	451	100.0	524	100.0	207	100.0
Number using the provider	288		233		260		104	
Number of reasons/ Respondent	1.90		1.94		2.02		1.99	

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Table II-11: Expenditure on ANC services by different socio-economics groups and by source

	Expenditure on ANC services (in Taka)								Average Expenditure (Taka)	
	No exp		1-25		26-50		50+		With Zero	Without Zero
	N	%	N	%	N	%	N	%		
<i>HH Expenditure level (taka per month)</i>										
Less than 3000	125	33.0	197	52.0	34	9.0	23	6.1	18.6	27.8
3001-5000	45	18.1	123	49.4	35	14.1	46	18.5	42.9	52.3
5001-7000	19	15.8	35	29.2	29	24.2	37	30.8	59.4	70.6
Above 7000	20	15.2	23	17.4	19	14.4	70	53.0	93.9	110.6
Total	209	23.8	378	43.0	117	13.3	176	20.0	42.3	55.5
<i>Source of services</i>										
Public	161	56.7	68	23.9	40	14.1	15	5.3	17.0	39.4
Private	26	11.3	21	9.1	39	17.0	144	62.6	110.3	124.3
UFHP	14	5.4	215	83.0	22	8.5	8	3.1	16.0	17.0
Other NGO	6	5.8	73	70.2	16	15.4	9	8.7	27.8	29.5
Others	2	50.0	2	50.0	-	-	-	-	3.8	7.6
Total	209	23.7	379	43.0	117	13.3	176	20.0	42.3	55.5

* All percentages are row percent values

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Table II-12: Expenditure on ANC services by different socio-economics groups and by source (NGO category A)

	Expenditure on ANC services (in Taka)								Average Expenditure (Taka)	
	No exp		1-25		26-50		50+		With Zero	Without Zero
	N	%	N	%	N	%	N	%		
<i>HH Expenditure level (taka per month)</i>										
Less than 3000	18	18.4	61	62.2	12	12.2	7	7.1	22.3	27.4
3001-5000	9	11.3	42	52.5	17	21.3	12	15.0	43.6	49.1
5001-7000	2	6.7	11	36.7	11	36.7	6	20.0	59.1	63.3
Above 7000	3	8.8	7	20.6	12	35.3	12	35.3	80.0	87.8
Total	32	13.2	121	50.0	52	21.5	37	15.3	42.0	48.4
<i>Source of services</i>										
Public	12	19.7	17	27.9	26	42.6	6	9.8	34.2	42.6
Private	9	23.1	1	2.6	4	10.3	25	64.1	127.8	166.2
UFHP	6	7.2	67	80.7	10	12.0	-		14.8	16.0
Other NGO	3	5.3	36	63.2	12	21.1	6	10.5	32.7	34.5
Others	2	100.0	-		-		-		0.0	-
Total	32	13.2	121	50.0	52	21.5	37	15.3	42.0	48.4

* All percentages are row percent values

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Table II-13: Expenditure on ANC services by different socio-economics groups and by source (NGO category B)

	Expenditure on ANC services (in Taka)								Average Expenditure (Taka)	
	No exp		1-25		26-50		50+		With Zero	Without Zero
	N	%	N	%	N	%	N	%		
<i>HH Expenditure level (taka per month)</i>										
Less than 3000	28	24.8	66	58.4	9	8.0	10	8.8	23.0	30.5
3001-5000	13	14.6	49	55.1	4	4.5	23	25.8	43.4	50.8
5001-7000	9	22.5	7	17.5	6	15.0	18	45.0	60.4	78.0
Above 7000	4	9.8	11	26.8	2	4.9	24	58.5	85.6	94.9
Total	54	19.1	133	47.0	21	7.4	75	26.5	43.7	54.1
<i>Source of services</i>										
Public	44	47.3	41	44.1	5	5.4	3	3.2	10.7	20.2
Private	5	5.2	15	15.6	9	9.4	67	69.8	98.6	104.1
UFHP	4	6.8	48	81.4	4	6.8	3	5.1	20.0	21.4
Other NGO	1	2.9	29	82.9	3	8.6	2	5.7	21.1	21.8
Others	-		1	100.0	-		-		10.0	10.0
Total	54	19.0	134	47.2	21	7.4	75	26.4	43.6	53.9

* All percentages are row percent values

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Table II-14: Expenditure on ANC services by different socio-economics groups and by source (NGO category C)

	Expenditure on ANC services (in Taka)								Average Expenditure (Taka)	
	No exp		1-25		26-50		50+		With Zero	Without Zero
	N	%	N	%	N	%	N	%		
<i>HH Expenditure level (taka per month)</i>										
Less than 3000	79	47.0	70	41.7	13	7.7	75	26.5	13.6	25.6
3001-5000	23	28.8	32	40.0	14	17.5	6	3.6	41.6	58.4
5001-7000	8	16.0	17	34.0	12	24.0	11	13.8	58.8	70.0
Above 7000	13	22.8	5	8.8	5	8.8	13	26.0	108.1	140.0
Total	123	34.6	124	34.9	44	12.4	34	59.6	41.4	63.4
<i>Source of services</i>										
Public	105	80.8	10	7.7	9	6.9	6	4.6	13.6	70.6
Private	12	12.6	5	5.3	26	27.4	52	54.7	114.8	131.4
UFHP	4	3.4	100	85.5	8	6.8	5	4.3	14.9	15.4
Other NGO	2	16.7	8	66.7	1	8.3	1	8.3	23.8	28.5
Others	-		1	100.0	-		-		5.0	5.0
Total	123	34.6	124	34.9	44	12.4	64	18.0	41.4	63.4

* All percentages are row percent value

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Table II-15: Source of ANC services by economic status of households

<i>HH Expenditure level (taka per month)</i>	Source of ANC services									
	Public		Private		UFHP		Other NGO		Others	
	N	%	N	%	N	%	N	%	N	%
All NGO										
Less than 3000	145	38.0	50	13.1	131	34.3	54	14.1	2	0.5
3001-5000	80	31.6	64	25.3	80	31.6	27	10.7	2	0.8
5001-7000	35	29.2	45	37.5	31	25.8	9	7.5	-	
Above 7000	28	21.1	74	55.6	17	12.8	14	10.5	-	
Total	288	32.4	233	26.2	259	29.2	104	11.7	4	0.8
NGO Category – A										
Less than 3000	29	29.0	7	7.0	40	40.0	23	23.0	1	1.0
3001-5000	16	19.8	16	19.8	32	39.5	16	19.8	1	1.2
5001-7000	9	30.0	4	13.3	9	30.0	8	26.7	-	
Above 7000	10	29.4	12	35.3	2	5.9	10	29.4	-	
Total	64	26.1	39	15.9	83	33.9	57	23.3	4	0.8
NGO Category – B										
Less than 3000	40	35.4	25	22.1	26	23.0	21	18.6	1	0.9
3001-5000	35	38.9	26	28.9	19	21.1	10	11.1	-	
5001-7000	14	35.0	21	52.5	4	10.0	1	2.5	-	
Above 7000	5	12.2	24	58.5	9	22.0	3	7.5	-	
Total	94	33.1	96	33.8	58	20.4	35	12.3	1	0.4
NGO Category – C										
Less than 3000	76	45.0	18	10.7	65	38.5	10	5.9	-	
3001-5000	29	35.4	22	26.8	29	35.4	1	1.2	1	1.2
5001-7000	12	24.0	20	40.0	18	36.0	-		-	
Above 7000	13	22.4	38	65.5	6	10.3	1	1.7	-	
Total	130	36.2	98	27.3	118	32.9	12	3.3	1	0.3

* All percentages are row percent values

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Table II-16: Comments on the level of payment made for ANC services by different socio-economic groups and by source

	It was high		It was alright		It was low		Don't Know		Average
	N	%	N	%	N	%	N	%	
<i>HH Expenditure level (taka per month)</i>									
Less than 3000	60	23.4	163	63.7	30	11.7	3	1.2	18.3
3001-5000	36	17.5	142	68.9	26	12.6	2	1.0	42.9
5001-7000	27	26.7	61	60.4	13	12.9	-	-	59.4
Above 7000	18	15.9	80	70.8	13	11.5	2	1.8	93.9
Total	141	20.9	446	66.0	82	12.1	7	1.0	42.34
<i>Source of services</i>									
Public	20	16.0	77	61.6	26	20.8	2	1.6	17.05
Private	56	27.1	128	61.8	18	8.7	5	2.4	110.28
UFHP	45	18.4	175	71.4	25	10.2	-	-	16.04
Other NGO	20	20.4	66	67.3	12	12.2	-	-	27.79
Others	-	-	1	50.0	1	50.0	-	-	3.75
Total	141	20.8	447	66.0	82	12.1	7	1.0	42.30

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Table II-17: Median willingness to pay for ANC by different socio-economic groups and NGO category

	Those who paid for the service			Those who did not pay		
	Median (Taka)			Median (Taka)		
	Pub	Pvt	NGO	Pub	Pvt	NGO
<i>HH Expenditure Level (taka per month)</i>						
Less than 3000	24.0	55.0	20.0	5.0	10.0	10.0
3001-5000	29.0	105.0	27.0	10.0	10.0	7.5
5001-7000	50.0	105.0	50.0	10.0	30.0	-
Above 7000	50.0	170.0	42.5	20.0	35.0	-
Total	35.0	150.0	27.0	10.0	20.0	10.0
<i>Urban Categories</i>						
A	43.0	170.0	30.0	5.0	10.0	10.0
B	20.0	140.0	10.0	10.0	15.0	-
C	70.0	120.0	10.0	5.0	30.0	-
Total	35.0	150.0	27.0	10.0	20.0	10.0

ANNEX II

Table II-18: Mode willingness to pay for ANC by different socio-economic groups and NGO category

	Those who paid for the service			Those who did not pay		
	Mode (Taka)			Mode (Taka)		
	Pub	Pvt	NGO	Pub	Pvt	NGO
<i>HH Expenditure Level (taka per month)</i>						
Less than 3000	10.0	30.0	10.0	5.0	10.0	10.0
3001-5000	20.0	150.0	10.0	5.0	10.0	5.0
5001-7000	100.0	100.0	50.0	5.0	25.0	-
Above 7000	50.0	150.0	10.0	10.0	20.0	-
Total	10.0	150.0	10.0	5.0	10.0	10.0
<i>Urban Categories</i>						
A	50.0	105.0	27.0	5.0	10.0	10.0
B	20.0	150.0	10.0	5.0	10.0	10.0
C	70.0	150.0	10.0	5.0	20.0	50.0
Total	10.0	150.0	10.0	5.0	10.0	10.0

Table III-1: Knowledge about the need for childhood immunization

HH Expenditure Level (taka per month)	Need immunization ?				Total	
	Yes		No		N	%
	N	%	N	%		
<=3000	1532	97.9	33	2.1	1565	100.0
3001-5000	868	98.7	11	1.3	879	100.0
5001-7000	334	97.9	7	2.1	341	100.0
>7000	349	96.1	14	3.9	363	100.0
Total	3083	97.9	65	2.1	3148	100.0

Table III-2: Women’s knowledge about the source of immunization in UFHP areas and by socio-economic groups and source of service

	TOTAL	Know the service ?		If know the service, specify the source				
		“No”	“Yes”	Public	Private	UFHP	Other NGO	Other
<i>Urban Categories</i>								
A	980 (100.0)	33 (3.4)	947 (96.6)	497 (52.9)	19 (2.0)	608 (64.2)	360 (38.0)	2 (0.2)
B	887 (100.0)	24 (2.7)	863 (97.3)	626 (72.5)	135 (15.6)	350 (40.6)	217 (25.1)	1 (0.1)
C	1281 (100.0)	19 (1.5)	1262 (98.5)	985 (78.1)	8 (0.6)	620 (49.1)	129 (10.2)	-
<i>Total (all categories)</i>	<i>3148 (100.0)</i>	<i>76 (2.4)</i>	<i>3072 (97.6)</i>	<i>2108 (68.6)</i>	<i>162 (5.3)</i>	<i>1578 (51.4)</i>	<i>706 (23.0)</i>	<i>3 (0.1)</i>
<i>Socio-economic group</i>								
<=3000	1565 (100.0)	42 (2.7)	1523 (97.3)	1064 (69.9)	76 (5.0)	741 (48.7)	374 (24.6)	3 (0.2)
3001-5000	879 (100.0)	23 (2.6)	856 (97.4)	583 (68.1)	44 (5.1)	444 (51.9)	212 (24.8)	-
5001-7000	341 (100.0)	5 (1.5)	336 (98.5)	227 (67.6)	21 (6.3)	187 (55.7)	58 (17.3)	-
>7000	363 (100.0)	6 (1.7)	357 (98.3)	234 (65.5)	21 (5.9)	206 (57.7)	62 (17.4)	-
<i>Total</i>	<i>3148 (100.0)</i>	<i>76 (2.4)</i>	<i>3072 (97.6)</i>	<i>2108 (68.6)</i>	<i>162 (5.3)</i>	<i>1578 (51.4)</i>	<i>706 (23.0)</i>	<i>3 (0.1)</i>

ANNEX III

Table III-3: Women's knowledge about the benefits of immunization by UFHP urban categories

Categories	Know about the benefits : The benefits are			Don't know the benefits	TOTAL (N)
	Prevent disease	Others benefits	Total		
A	835 (85.6)	155 (15.9)	976 (99.6)	4 (.4)	980 (100.0)
B	714 (81.5)	195 (22.3)	876 (98.8)	11 (1.2)	887 (100.0)
C	1026 (81.4)	249 (19.8)	1260 (98.4)	21 (1.6)	1281 (100.0)
<i>Total (all categories)</i>	<i>2575 (73.1)</i>	<i>599 (19.2)</i>	<i>3112 (98.9)</i>	<i>36 (1.1)</i>	<i>3148 (100.0)</i>

Table III-4: Distribution of Immunization events by date of last visit and urban categories

When last Immunized	Total number			Percentage			Total	Mean Age
	A	B	C	A	B	C		
00 months ago	61	75	61	22.8	25.3	15.6	197	5.13
01 months ago	46	61	52	17.2	20.6	13.3	159	6.87
02 months ago	28	30	32	10.5	10.1	8.2	90	7.26
3-4 months ago	37	41	66	13.9	13.9	16.8	144	8.20
5+ months ago	11	20	37	4.1	6.8	9.4	68	9.45
Not Immunized	84	69	144	31.5	23.3	36.7	297	3.21
Total	267	296	392	100	100	100	955	5.81

Table III-5: Reasons for Selecting providers for Immunization by different service providers

Reasons	Public Sector		Private		UFHP		Other NGO		Others	
	N	%	N	%	N	%	N	%	N	%
Near to the house	129	35.7	6	16.7	115	51.8	35	27.8	1	33.3
Free service/Free Drugs	125	34.6	6	16.7	39	17.6	27	21.4	1	33.3
Convenient Time	71	19.7	13	36.1	27	12.2	30	23.8	-	-
Drugs Available	1	.3	2	5.6	8	3.6	9	7.1	-	-
Less Waiting time	6	1.7	2	5.6	7	3.2	6	4.8	-	-
Clean Facility	2	.6			2	.9	3	2.4	-	-
Qualified provider	13	3.6	3	8.3	7	3.2	13	10.3	-	-
Female provider	-	-	-	-	-	-	-	-	-	-
Well behaved provider	1	.3	3	8.3	9	4.1	1	.8	-	-
Others	13	3.6	1	2.8	8	3.6	2	1.3	1	33.3
Total	361	100	36	100	222	100	126	100	3	100

ANNEX III

Table III-6: Expenditure on Immunization Services by different socio-economic groups and by source

	Expenditure in Taka for the last immunisation visit								Average Taka	
	No exp		1-10		11-25		26-50		With Zero	Without Zero
HH Expenditure level										
Less than 3000	103	55.1	73	39.0	9	4.8	2	1.1	3.4	7.6
3001-5000	54	38.8	72	51.8	13	9.4	-		4.5	7.4
5001-7000	29	54.7	23	43.4	1	1.9	-		2.5	5.6
Above 7000	33	50.8	27	41.5	4	6.2	1	1.5	3.9	8.1
Total	219	49.3	195	43.9	27	6.1	3	.7	3.7	7.3
NGO category										
A	30	22.2	78	57.8	25	18.5	2	1.5	7.0	8.9
B	77	46.4	87	52.4	2	1.2	-		3.1	5.8
C	113	78.5	30	20.8	-		1	.7	1.3	6.3
Total	220	49.4	195	43.8	27	6.1	3	.7	3.7	7.3
Source of services										
Public	157	73.4	55	25.7	2	.9	-		1.4	5.3
Private	2	10.0	16	80.0	2	10.0	-		6.5	7.2
UFHP	52	36.9	79	56.0	9	6.4	1	.7	5.0	7.9
Oth NGO	8	11.8	44	64.7	14	20.6	2	2.9	7.5	8.5
Others	1	50.0	1	50.0	-		-		2.5	5.0
Total	220	49.4	195	43.8	27	6.1	3	.7	3.7	7.3

Table III-7: Comments on the level of payment made for Immunization services by socio-economic groups and by source
(For those who paid a fee)

	It was high		It was alright		It was low	
HH Expenditure level						
Less than 3000	17	20.2	59	70.2	8	9.5
3001-5000	15	17.6	63	74.1	7	8.2
5001-7000	5	20.8	13	54.2	6	25.0
Above 7000	2	6.5	21	67.7	8	25.8
Total	39	17.4	155	69.2	29	12.9
Source of Services						
Public	7	12.3	46	80.7	4	7.0
Private	1	5.6	15	83.3	2	11.1
UFHP	17	19.3	55	62.5	16	18.2
Oth NGO	14	23.3	39	65.0	6	10.0
Others	-		-		-	
Total	39	17.4	155	69.2	29	12.9

Table III-8: Average willingness to pay for Immunization services at UFHP by different socio-economic groups and by NGO category

	Those who paid for the service	Those who did not pay
	Average	Average
<i>HH Expenditure level</i>		
Less than 3000	11.67	6.0
3001-5000	13.06	6.0
5001-7000	10.78	13.1
Above 7000	19.94	9.2
Total	13.7	7.6
<i>NGO Category</i>		
NGOCAT A	14.8	4.0
B	12.5	6.7
C	13.0	9.0
Total	13.7	7.6

ANNEX IV

Table IV-1: Women's knowledge about ARI in UFHP areas

Categories	Total women (N)	No. of women who could identify the acute case of ARI and need of health care	% of women who could identify the acute case of ARI and need for health care
A	980	547	55.8
B	887	376	42.4
C	1281	591	46.1
<i>Total (all categories)</i>	<i>3148</i>	<i>1514</i>	<i>48.1</i>

ANNEX IV

Table IV-2: Women’s knowledge about the source of treatment for ARI in UFHP areas and by socio-economic group

	TOTAL	Know source of care		Where can one get care for ARI ?				
		“No”	“Yes”	Public	Private	UFHP	Other NGO	Other
<i>Urban Categories</i>								
A	980 (100.0)	70 (7.1)	910 (92.9)	496 (54.5)	575 (63.2)	178 (19.6)	150 (16.5)	2 (0.2)
B	887 (100.0)	33 (3.7)	854 (96.3)	270 (31.6)	744 (87.1)	81 (9.5)	12 (1.4)	-
C	1281 (100.0)	29 (2.3)	1252 (97.7)	650 (51.9)	976 (78.0)	171 (13.7)	46 (3.7)	1 (0.1)
<i>Total (all categories)</i>	<i>3148 (100.0)</i>	<i>132 (4.2)</i>	<i>3016 (95.8)</i>	<i>1416 (46.9)</i>	<i>2295 (76.1)</i>	<i>430 (14.3)</i>	<i>208 (6.9)</i>	<i>3 (0.1)</i>
<i>Socio-economic group</i>								
<=3000	1565 (100.0)	75 (4.8)	1490 (95.2)	729 (48.9)	1120 (75.2)	205 (13.8)	115 (7.7)	1 (0.1)
3001-5000	879 (100.0)	35 (4.0)	844 (96.0)	389 (46.1)	635 (75.2)	121 (14.3)	63 (7.5)	1 (0.1)
5001-7000	341 (100.0)	14 (4.1)	327 (95.9)	146 (44.6)	260 (79.5)	42 (12.8)	11 (3.4)	1 (0.3)
>7000	363 (100.0)	8 (2.2)	355 (97.8)	152 (42.8)	280 (79.5)	62 (17.5)	19 (5.4)	-
<i>Total</i>	<i>3148 (100.0)</i>	<i>132 (4.2)</i>	<i>3016 (95.8)</i>	<i>1416 (46.9)</i>	<i>2295 (76.1)</i>	<i>430 (14.3)</i>	<i>208 (6.9)</i>	<i>3 (0.1)</i>

ANNEX IV

Table IV-3: knowledge about ARI related Service Providers who provide Service Free of Cost by Urban Categories and Household Socio-economic Status

	Know a free service provider ?			TOTAL
	“Yes”	“No”	“Don’t know”	
<i>Urban Categories</i>				
A	94 (10.3)	610 (67.0)	206 (22.6)	910 (100.0)
B	80 (9.4)	590 (69.1)	184 (21.5)	854 (100.0)
C	466 (37.2)	465 (37.1)	321 (25.6)	1252 (100.0)
<i>Total (all categories)</i>	<i>640</i> <i>(21.2)</i>	<i>1665</i> <i>(55.2)</i>	<i>711</i> <i>(23.6)</i>	<i>3016</i> <i>(100.0)</i>
<i>Socio-economic group</i>				
<=3000	363 (24.4)	777 (52.1)	350 (23.5)	1490 (100.0)
3001-5000	154 (18.2)	496 (58.8)	194 (23.0)	844 (100.0)
5001-7000	59 (18.0)	181 (55.4)	87 (26.6)	327 (100.0)
>7000	64 (18.0)	211 (59.4)	80 (22.5)	355 (100.0)
<i>Total</i>	<i>640</i> <i>(21.2)</i>	<i>1665</i> <i>(55.2)</i>	<i>711</i> <i>(23.6)</i>	<i>3016</i> <i>(100.0)s</i>

ANNEX IV

Table IV-4: knowledge about ARI treatment providers charging money in UFHP areas by socio-economic group

	Know a provider charging money by service				TOTAL (N)
	UFHP	Others	Total "Yes"	No	
<i>Urban Categories</i>					
A	176 (21.2)	783 (94.1)	832 (91.4)	78 (8.6)	910 (100.0)
B	78 (9.5)	791 (96.6)	819 (95.9)	35 (4.1)	854 (100.0)
C	186 (17.5)	955 (89.9)	1062 (84.8)	190 (15.2)	1252 (100.0)
<i>Total (all categories)</i>	<i>440 (16.2)</i>	<i>2529 (93.2)</i>	<i>2713 (90.0)</i>	<i>303 (10.0)</i>	<i>3016 (100.0)</i>
<i>Socio-economic group</i>					
<=3000	207 (15.6)	1233 (92.9)	1327 (89.1)	163 (10.9)	1490 (100.0)
3001-5000	127 (16.4)	726 (93.6)	776 (91.9)	68 (8.1)	844 (100.0)
5001-7000	41 (14.2)	278 (96.2)	289 (88.4)	38 (11.6)	327 (100.0)
>7000	65 (20.2)	292 (91.0)	321 (90.4)	34 (9.6)	355 (100.0)
<i>Total</i>	<i>440 (16.2)</i>	<i>2529 (93.2)</i>	<i>2713 (90.0)</i>	<i>303 (10.0)</i>	<i>3016 (100.0)</i>

Table IV-5: Women's knowledge about service charges for ARI treatment in UFHP areas by socio-economic groups

	Average of maximum fee mentioned		Average of minimum fee mentioned		Average of the UFHP price		UFHP price							
	N	Avg	N	Avg	N	Avg	High		Low		Ok		Total	
Category	N	Avg	N	Avg	N	Avg	N	%	N	%	N	%	N	%
A	704	69.80	704	40.32	146	17.58	31	21.2	14	9.6	101	69.2	146	100
B	772	58.66	772	35.16	67	19.07	15	22.4	11	16.4	41	61.2	67	100
C	918	66.04	918	45.51	155	9.53	18	11.6	25	16.1	112	72.3	155	100
Total	2387	64.76	2394	40.64	368	14.46	64	17.4	50	13.6	254	69.0	368	100
Socio- economic group	N	Avg	N	Avg	N	Avg	N	%	N	%	N	%	N	%
Less than 3000	1162	49.52	1167	31.48	182	13.23	37	20.3	21	11.5	124	68.1	182	100
3001-5000	684	67.98	685	41.84	108	14.99	18	16.7	13	12.0	77	71.3	108	100
5001-7000	253	85.61	254	54.20	27	18.19	3	11.1	1	3.7	23	85.2	27	100
Above 7000	288	100.29	288	62.98	51	15.75	6	11.8	15	29.4	30	58.8	51	100
Total	2387	64.76	2394	40.64	368	14.46	64	17.4	50	13.6	254	69.0	366	100

ANNEX IV

Table IV-6: knowledge about the source of treatment for diarrhoea in UFHP areas by socio-economic groups

	TOTAL	“No”	“Yes”	Breakdown of “Yes”				
				Public	Private	UFHP	Other NGO	Other
<i>Categories</i>								
A	980 (100.0)	43 (4.4)	937 (95.6)	446 (47.6)	501 (53.5)	84 (9.0)	295 (31.5)	1 (0.1)
B	887 (100.0)	21 (2.4)	866 (97.6)	416 (48.0)	631 (72.9)	41 (4.7)	133 (15.4)	-
C	1281 (100.0)	19 (1.5)	1262 (98.5)	960 (76.1)	702 (55.6)	64 (5.1)	11 (0.9)	1 (0.1)
<i>Total (all categories)</i>	<i>3148</i> <i>(100.0)</i>	<i>83</i> <i>(2.6)</i>	<i>3065</i> <i>(97.4)</i>	<i>1822</i> <i>(59.5)</i>	<i>1834</i> <i>(59.8)</i>	<i>189</i> <i>(6.2)</i>	<i>439</i> <i>(14.3)</i>	<i>2</i> <i>(0.1)</i>
<i>Socio-economic group</i>								
<=3000	1565 (100.0)	46 (2.9)	1519 (97.1)	943 (62.1)	877 (57.7)	75 (4.9)	203 (13.4)	-
3001-5000	879 (100.0)	23 (2.6)	856 (97.4)	500 (58.4)	506 (59.1)	46 (5.4)	138 (16.1)	2 (0.2)
5001-7000	341 (100.0)	10 (2.9)	331 (97.1)	190 (57.4)	219 (66.2)	27 (8.2)	34 (10.30)	-
>7000	363 (100.0)	4 (1.1)	359 (98.9)	189 (52.7)	232 (64.6)	41 (11.4)	64 (17.8)	-
<i>Total</i>	<i>3148</i> <i>(100.0)</i>	<i>83</i> <i>(2.6)</i>	<i>3065</i> <i>(97.4)</i>	<i>1822</i> <i>(59.5)</i>	<i>1834</i> <i>(59.8)</i>	<i>189</i> <i>(6.2)</i>	<i>439</i> <i>(14.3)</i>	<i>2</i> <i>(0.1)</i>

ANNEX IV

Table IV-7: Women’s knowledge about providers who provide treatment for diarrhoea free of charge in UFHP areas by socio-economic groups

	“Yes”	“No”	“Don’t know”	TOTAL
<i>Categories</i>				
A	222 (22.7)	536 (54.7)	222 (22.7)	980 (100.0)
B	258 (29.1)	446 (50.3)	183 (20.6)	887 (100.0)
C	613 (47.9)	427 (33.3)	241 (18.8)	1281 (100.0)
<i>Total (all categories)</i>	<i>1093</i> <i>(34.7)</i>	<i>1409</i> <i>(44.8)</i>	<i>646</i> <i>(20.5)</i>	<i>3148</i> <i>(100.0)</i>
<i>Socio-economic group</i>				
<=3000	596 (38.1)	665 (42.5)	304 (19.4)	1565 (100.0)
3001-5000	282 (32.1)	420 (47.8)	177 (20.1)	879 (100.0)
5001-7000	98 (28.7)	164 (48.1)	79 (23.2)	341 (100.0)
>7000	117 (32.2)	160 (44.1)	86 (23.7)	363 (100.0)

<i>Total</i>	<i>1093</i> <i>(34.7)</i>	<i>1409</i> <i>(44.8)</i>	<i>646</i> <i>(20.5)</i>	<i>3148</i> <i>(100.0)</i>
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ANNEX IV

Table IV-8: Women’s knowledge about the treatment providers for diarrhoea charging money in UFHP areas and by socio-economic group

	“Yes”			“No”	“Don’t know”	TOTAL (N)
	UFHP	Others	Total “Yes”			
<i>Categories</i>						
A	83 (10.7)	754 (97.2)	776 (79.2)	106 (10.8)	98 (10.0)	980 (100.0)
B	38 (4.8)	774 (97.5)	794 (89.5)	19 (2.1)	74 (8.3)	887 (100.0)
C	88 (10.1)	823 (94.1)	875 (68.3)	158 (12.3)	248 (19.4)	1281 (100.0)
<i>Total (all categories)</i>	209 (8.5)	2351 (96.2)	2445 (77.7)	283 (9.0)	420 (13.3)	3148 (100.0)
<i>Socio economic group</i>						
<=3000	88 (7.6)	1111 (96.40)	1153 (73.7)	172 (11.0)	240 (15.3)	1565 (100.0)
3001-5000	53 (7.5)	681 (96.3)	707 (80.4)	68 (7.7)	104 (11.8)	879 (100.0)
5001-7000	30 (10.6)	270 (95.4)	283 (83.0)	19 (5.6)	39 (11.4)	341 (100.0)
>7000	38 (12.6)	289 (95.7)	302 (83.2)	24 (6.6)	37 (10.2)	363 (100.0)
<i>Total</i>	209 (8.5)	2351 (96.2)	2445 (77.7)	283 (9.0)	420 (13.3)	3148 (100.0)

ANNEX IV

Table IV-9: Source of care for illness by different categories of UFHP areas

Source of Services	UFHP area							
	A		B		C		Total	
Public	44	12.1	40	13.4	52	11.3	136	12.1
Private	294	80.8	248	83.2	392	84.8	934	83.1
UFHP	13	3.6	10	3.4	10	2.2	33	2.9
NGO	13	3.6	-		2	.4	15	1.3
Others	-		-		6	1.3	6	.5
Sub-Total	364	55.4	298	50.0	462	46.0	1124	49.8
Wait & See and Home care	293	44.6	298	50.0	542	54.0	1133	50.2
Grand Total	657	100.0	596	100.0	1004	100.0	2257	100.0

Table IV-10: Average Expenditure per illness episode by Source of services by different categories of UFHP areas

Source of Services	UFHP area		
	A	B	C
Public	164.5	26.8	87.61
Private	87.2	85.5	64.81
UFHP	22.7	15.8	31.5
NGO	86.2	-	5.0
Others	-	-	1.3
Total	93.9	75.2	65.74

ANNEX V

Table V-1: Women’s knowledge about the source for getting family planning methods in UFHP areas by Socio-economic group

	TOTAL	Know source of service		Not applicable	Where can one get care for Family planning ?			
		No	Yes		Public	Private	UFHP	Other NGO
Urban Categories								
A	980 (100.0)	20 (2.0)	953 (97.2)	7 (0.7)	380 (39.9)	620 (65.0)	526 (55.2)	231 (24.2)
B	887 (100.0)	13 (1.5)	856 (96.5)	18 (2.0)	498 (58.2)	641 (74.9)	354 (41.4)	147 (17.2)
C	1281 (100.0)	15 (1.2)	1230 (96.0)	36 (2.8)	930 (75.6)	770 (62.6)	527 (42.8)	113 (9.2)
<i>Total (all categories)</i>	<i>3148 (100.0)</i>	<i>48 (1.5)</i>	<i>3039 (96.5)</i>	<i>61 (1.9)</i>	<i>1808 (59.5)</i>	<i>2031 (66.8)</i>	<i>1407 (46.3)</i>	<i>491 (16.2)</i>
Socio-economic group								
<=3000	1565 (100.0)	24 (1.5)	1506 (96.2)	35 (2.2)	935 (62.1)	955 (63.4)	710 (47.1)	260 (17.3)
3001-5000	879 (100.0)	16 (1.8)	849 (96.6)	14 (1.6)	486 (57.2)	574 (67.6)	400 (47.1)	166 (19.6)
5001-7000	341 (100.0)	7 (2.1)	326 (95.6)	8 (2.3)	192 (58.9)	242 (74.2)	139 (42.6)	30 (9.2)
>7000	363 (100.0)	1 (0.3)	358 (98.6)	4 (1.1)	195 (54.5)	260 (72.6)	158 (44.1)	35 (9.8)
<i>Total</i>	<i>3148 (100.0)</i>	<i>48 (1.5)</i>	<i>3039 (96.5)</i>	<i>61 (1.9)</i>	<i>1808 (59.5)</i>	<i>2031 (66.8)</i>	<i>1407 (46.3)</i>	<i>491 (16.2)</i>

ANNEX V

Table V-2: Women’s knowledge about family planning methods related service providers who provides service free of cost by urban categories and socio-economic group

	Know a free service provider			TOTAL
	“Yes”	“No”	“Don’t know”	
<i>Urban Categories</i>				
A	95 (9.7)	603 (61.5)	282 (28.8)	980 (100.0)
B	270 (30.4)	381 (43.0)	236 (26.6)	887 (100.0)
C	644 (50.3)	328 (25.6)	309 (24.2)	1281 (100.0)
<i>Total (all categories)</i>	<i>1009</i> <i>(32.1)</i>	<i>1312</i> <i>(41.7)</i>	<i>827</i> <i>(26.3)</i>	<i>3148</i> <i>(100.0)</i>
<i>Socio-economic group</i>				
<=3000	589 (37.5)	577 (36.9)	399 (25.4)	1565 (100.0)
3001-5000	243 (27.6)	424 (48.2)	212 (24.1)	879 (100.0)
5001-7000	83 (24.3)	141 (41.3)	117 (34.3)	341 (100.0)
>7000	94 (25.9)	170 (46.8)	99 (27.3)	363 (100.0)
<i>Total</i>	<i>1009</i> <i>(32.1)</i>	<i>1312</i> <i>(41.7)</i>	<i>827</i> <i>(26.3)</i>	<i>3148</i> <i>(100.0)</i>

ANNEX V

Table V-3: Source of services for selecting providers for Family Planning by different NGO category

NGO Category	Public Sector		Private		UFHP		Other NGO		Others	
A	48	11.7	187	45.6	142	34.6	21	5.1	12	2.9
B	100	22.6	169	38.1	125	28.2	20	4.5	29	6.5
C	159	35.7	144	32.3	104	23.3	9	2.0	30	6.7
Total	307	23.6	500	38.5	371	28.6	50	3.8	71	5.5

ANNEX V

Table V-4: Source of supplies by type of Family Planning method

Family Planning Method	Public Sector		Private		UFHP		Other NGO		Others		TOTAL	
	N	%	N	%	N	%	N	%	N	%	N	%
Pill/Condom	178	58.0	481	96.2	161	43.4	20	3.5	41	7.2	912	70.2
Injection	64	20.8	6	1.2	207	55.8	23	5.7	21	5.5	294	22.6
IUD/Norplant	20	6.5	3	.3	3	.8	3	2.3	3	2.3	32	2.5
Sterilization	45	14.7	10	2.0	-		4	2.1	5	2.6	61	4.7
Total	307	23.6	500	38.5	371	28.6	50	3.8	71	5.5	1299	100.0

Table V-5: Reasons for selecting providers for Family Planning

Reasons	Public Sector		Private		UFHP		Other NGO		Others		TOTAL	
	N	%	N	%	N	%	N	%	N	%	N	%
Near to the house	72	15.3	111	16.6	290	45.2	13	16.9	17	19.3	503	25.8
Convenient Time	111	23.6	303	45.4	149	23.2	25	32.5	31	35.2	619	31.8
Well behaved provider	16	3.4	7	1.0	42	6.5	6	7.8	1	1.1	72	3.7
Provider provides lot of information	1	0.2	1	0.1	4	0.6	-	-	-	-	6	0.3
Qualified provider	29	6.2	22	3.3	32	5.0	14	18.2	-	-	97	5.0
Free service	137	29.1	-	-	-	-	7	9.1	2	2.3	146	7.5
Services are cheap	27	5.7	3	0.4	37	5.8	4	5.2	3	3.4	74	3.8
Privacy maintained	10	2.1	72	10.8	8	1.2	-	-	12	13.6	102	5.2
Less Waiting time	1	0.2	11	1.6	11	1.7	1	1.3	3	3.4	27	1.4
The provider is known	10	2.1	14	2.1	18	2.8	4	5.2	5	5.7	51	2.6
Not aware of other facility	18	3.8	13	1.9	6	0.9	1	1.3	1	1.1	39	2.0
This provider's methods suits me	25	5.3	109	16.3	18	2.8	2	2.6	12	13.6	166	8.5
Clean Facility	1	0.2	-	-	13	2.0	-	-	-	-	14	0.7
Others	10	2.1	2	0.3	14	2.2	-	-	1	1.1	27	1.4
TOTAL	471	100.0	668	100.0	642	100.0	77	100.0	77	100.0	1946	100.0

ANNEX V

Table V-6: Expenditure on Family Planning services by different socio-economic groups and source of services

	Expenditure in Taka for the last Family Planning services								Average Taka	
	No exp		1-10		11-25		25+		With Zero	Without Zero
HH Expenditure level										
Less than 3000	149	27.0	320	58.1	63	11.4	19	3.4	6.4	8.8
3001-5000	83	21.7	224	58.5	58	15.1	18	4.7	7.8	9.9
5001-7000	27	22.9	60	50.8	20	16.9	11	9.3	8.7	11.3
Above 7000	27	16.4	69	41.8	43	26.1	26	15.8	12.9	15.4
Total	286	23.5	673	55.3	184	15.1	74	6.1	7.9	10.4
NGO category										
A	32	8.2	266	68.0	65	16.6	28	7.2	10.0	10.9
B	107	26.1	222	54.1	65	15.9	16	3.9	7.1	9.6
C	147	35.3	186	44.6	54	12.9	30	7.2	6.8	10.5
Total	286	23.5	674	55.3	184	15.1	74	6.1	7.9	10.4
Source of services										
Public	250	83.3	44	14.7	5	1.7	1	.3	1.1	6.5
Private	5	1.1	224	51.3	138	31.6	70	16.0	13.6	13.7
UFHP	9	2.4	342	92.2	20	5.4	-		7.0	7.1
Oth NGO	10	22.4	28	57.1	10	20.4	-		6.6	8.5
Others	11	18.0	36	59.0	11	18.0	3	4.9	7.9	9.7
Total	286	23.5	674	55.3	184	15.1	74	6.1	7.9	10.4

ANNEX V

Table V-7: Comments on the level of payment made for Family planning services by different socio-economic groups and by source of service

	<i>It was high</i>		It was alright		It was low		Average FP Cost
HH Expenditure level							
Less than 3000	83	20.6	281	69.9	38	9.5	6.39
3001-5000	68	22.7	208	69.6	23	7.7	7.75
5001-7000	16	17.4	67	72.8	9	9.8	8.74
Above 7000	25	18.1	94	68.1	18	13.8	12.91
Total	192	20.6	650	69.8	89	9.6	7.93
Source of services							
Public	8	16.0	34	68.0	8	16.0	1.09
Private	96	22.2	305	70.6	31	7.2	13.59
UFHP	65	17.9	252	69.4	46	12.7	6.97
NGO	5	13.5	29	78.4	3	8.1	6.59
Others	18	36.0	30	60.0	2	4.0	7.95
Total	192	20.6	650	69.7	90	9.7	7.93

ANNEX V

Table V-8: Willing to pay for Family Planning services more than what has been paid by different socio-economic groups and by source of service and by NGO category

	<i>Will pay more</i>			
	Yes		No	
HH Expenditure level				
Less than 3000	185	46.4	214	53.6
3001-5000	151	50.3	149	49.7
5001-7000	55	59.8	37	40.2
Above 7000	95	69.9	41	30.1
Total	486	52.4	441	47.6
Source of services				
Public	28	56.0	22	44.0
Private	251	58.4	179	41.6
UFHP	171	47.2	191	52.8
Other NGO	19	51.4	18	48.6
Others	18	36.7	31	63.3
Total	487	52.5	441	47.5
Source of services				
A	191	53.4	167	46.6
B	157	52.3	143	47.7
C	139	51.5	131	48.5
Total	487	52.5	441	47.5

Table VI-1: Average waiting time in minutes and travel cost and treatment costs in taka by service type in UFHP clinic

Service type	Average waiting time	Average Travel cost	Average Treatment cost
Pill/Condom	7.20	5.10	17.20
Injection	9.73	3.10	8.17
<i>Other FP</i>	14.40	3.20	13.40
ANC	18.41	4.26	22.13
Maternal Health	14.40	2.90	13.20
Child Health	15.53	6.53	23.16
Child Immunization	27.66	4.37	9.90
Referrals	17.07	4.29	28.68
Others	7.17	3.17	25.83
All	16.57	4.23	17.93

Table VI-2: Will pay more than what is paid by service type in UFHP clinic

Service type	Yes (%)	Yes, if quality/ behaviour improves(%)	No (%)	Total
Pill/Condom	60.0	-	40.0	10 6.20
Injection	71.4	3.6	25.0	28 17.4
<i>Other FP</i>	100.0	-	-	4 2.5
ANC	62.2	5.4	32.4	37 23.0
Maternal Health	62.5	-	37.5	8 5.0
Child Health	78.9	-	21.1	19 11.8
Child Immunization	64.3	-	35.7	28 17.4
Referrals	82.6	4.3	13.0	23 14.3
Others	50.0	25.0	25.0	4 2.5
All	69.6	3.1	27.3	161 100.0

Table VI-3: Average willingness to pay in Taka by service type in UFHP clinic

Service type	Average willingness to pay
Pill/Condom	25.00
Injection	15.68
<i>Other FP</i>	26.75
ANC	36.78
Maternal Health	30.88
Child Health	39.47
Child Immunization	22.82

ANNEX VI

“X” indicates services not provided by respective facilities.

Table V1-4: Services provided by UFHP and NGO facilities

No	Services	UFHP Category A	Other NGO Category A	UFHP Category C	Other NGO Category C
Family Planning Services					
01	Oral Pills				
02	Condoms				
03	IUDs				X
04	Injectables				X
05	Norplant	X	X	X	X
06	Vasectomy	X	X	X	X
07	Tubectomy		X		X
08	Post-partum FP counseling	X		X	X
09	Side effects management	X		X	X
Reproductive Health Services					
10	Antenatal care (ANC)				
11	Postnatal Care(PNC)				
12	TT immunization				
13	EOC	X	X	X	X
14	Management of RTI/STD				
15	STD/RTI counseling				
16	Infertility diagnosis	X		X	X
17	Infertility treatment	X		X	X
18	Post- abortion counseling				
Child Health					
19	Child immunization				
20	ARI treatment				
21	ORS/ Diarrhoea Treatment				
22	Breastfeeding counseling				
23	Vitamin-A- supplementation				
24	Nutrition education				

ANNEX VI

Table V1-5: Laboratory Services provided by UFHP and NGO facilities

No	Services	UFHP	Other NGO	UFHP	Other NGO
		Category	Category	Category	Category
		A	A	C	C
01	Urine albumin test				X
02	Urine sugar test				X
03	Blood Hd test				X
04	Pregnancy test				X
05	Blood R/E			X	X
06	Stool R/E			X	X
07	Urine R/E			X	X
08	BT, CT			X	X
09	Platelate count			X	X
10	Occult Blood test			X	X
11	RA test		X	X	X
12	HBsAg			X	X
13	VDRL			X	X
14	ASO titre			X	X

Table V1-6: Registration fee for the facilities

Fee	UFHP	Other NGO	UFHP	Other NGO
	Category	Category	Category	Category
	A	A	C	C
Registration Fee	Tk. 5	Tk. 10	Tk. 5	No registration fee

Table VI-7: Staff positions at the facilities

No	Staff positions	UFHP Category A	Other NGO Category A	UFHP Category C	Other NGO Category C
01	Medical Officer	1 Part time 1 Also present	2	1	1
02	Nurse				
03	FWV				1
04	Paramedic	4	2	2	
05	Senior Service Promoter	1		1	
06	Service Promoter	3		1	
07	Counselor	2	1	1	
08	Clinic Assistant	1			
09	FP Fieldworker		6		8
10	Health Fieldworker				
11	Pharmacist / Druggist				
12	Accountant / Office Assistant				
13	Clerk/Record Keeper				
14	Receptionist		1		
15	Cleaner / Sweeper				
16	Community Mobilizer				
17	Depotholder				
18	Aya	1	4		1
19	Guard	1		1	
20	Cleaner			1	
21	Lab. technicians	1			

ANNEX VII

Table VII-5: Satisfaction with service provided for ANC by different socio-economic groups and by source of service and by NGO category

EXPHH	Enough information	Good behavior	Good provider	Clean facility	Less waiting time
0000—3000	311 (82.3)	373 (98.9)	367 (97.6)	343 (91.5)	310 (81.6)
3001—5000	200 (79.7)	243 (97.6)	247 (99.2)	201 (82.7)	211 (84.1)
5001--7000	97 (82.9)	115 (99.1)	115 (99.1)	99 (85.3)	109 (92.4)
>7000	119 (90.2)	128 (98.5)	130 (100.0)	113 (85.6)	120 (90.2)
NGO category					
A	156 (64.2)	238 (98.8)	236 (97.9)	200 (83.0)	215 (88.1)
B	267 (94.7)	278 (98.6)	281 (99.6)	266(95.3)	259 (91.2)
C	305 (86.2)	344(98.3)	343 (98.3)	291 (83.9)	276 (77.7)
By provider					
Public	216 (75.8)	272 (96.1)	277 (98.2)	238 (83.2)	251 (88.1)
Private	216 (94.3)	227 (99.6)	228 (100.0)	219 (94.0)	205 (88.0)
UFHP	210 (81.7)	254 (100.0)	248 (97.6)	208 (86.3)	202 (78.6)
Other NGO	83 (79.8)	103 (99.0)	103 (99.0)	89 (86.4)	91 (87.5)
Others	3 (75.0)	4 (100.0)	4 (100.0)	3 (75.0)	1 (25.0)

ANNEX VII

Table VII-2: Satisfaction with service provided for Immunization by different socio-economic groups and by source of service and by NGO category

EXPHH	Enough information	Good behavior	Good provider	Clean facility	Less waits time
0000—3000	130 (71.0)	181 (96.8)	179 (99.4)	153 (86.9)	145 (80.1)
3001—5000	85 (61.6)	137 (98.6)	130 (99.2)	113 (83.1)	110 (80.3)
5001—7000	37 (71.2)	51 (96.2)	52 (100.0)	41 (78.8)	44 (83.0)
>7000	46 (74.2)	62 (92.5)	62 (100.0)	49 (79.0)	56 (90.3)
NGO Category					
A	75 (56.4)	132 (99.2)	128 (100.0)	102 (77.9)	98 (74.2)
B	127 (77.0)	165 (100.0)	165 (100.0)	152 (92.7)	137 (84.0)
C	96 (69.6)	135 (98.5)	131 (98.5)	103 (78.0)	121 (87.1)
By provider					
Public	135 (64.3)	209 (99.5)	204 (99.5)	167 (81.1)	183 (87.6)
Private	18 (90.0)	20 (100.0)	20 (100.0)	18 (90.0)	17 (85.0)
UFHP	99 (71.7)	135 (98.5)	133 (99.3)	111 (82.8)	117 (84.2)
Other NGO	45 (68.2)	66 (100.0)	65 (100.0)	60 (90.9)	37 (57.8)
Others	1 (50.0)	2 (100.0)	2 (100.0)	1 (100.0)	2 (100.0)

ANNEX VII

Table VII-3: Satisfaction with service provided for Family Planning by different socio-economic groups and by source of service and by NGO category

EXPHH	Enough information	Good behavior	Good provider	Clean facility	Less waits times
0000—3000	267 (74.2)	356 (98.3)	332 (97.1)	273 (90.7)	289 (86.0)
3001—5000	173 (73.9)	233 (99.6)	217 (97.7)	162 (87.1)	171 (82.2)
5001—7000	50 (78.1)	63 (98.4)	61 (100.0)	40 (74.1)	46 (82.1)
>7000	57 (85.1)	66 (95.7)	63 (100.0)	42 (80.8)	51 (89.5)
NGO Category					
A	111 (52.1)	210 (99.1)	194 (97.5)	148 (77.1)	165 (82.9)
B	215 (92.3)	233 (98.7)	229 (100.0)	200 (96.6)	171 (82.6)
C	221 (79.2)	275 (97.9)	250 (96.2)	169 (87.1)	221 (88.0)
By provider					
Public	225 (77.3)	288 (99.0)	259 (95.2)	187 (87.4)	208 (77.6)
Private	16 (76.2)	21 (84.0)	21 (100.0)	17 (81.0)	16 (80.0)
UFHP	268 (74.0)	359 (98.9)	346 (99.4)	276 (86.8)	301 (92.9)
Other NGO	37 (75.5)	49 (100.0)	46 (100.0)	35 (92.1)	32 (72.7)
Others	1 (50.0)	1 (100.0)	1 (100.0)	2 (100.0)	-

ANNEX VII

Table VII-4: Satisfaction with service provided for Illness by different socio-economic groups and by source of service and by NGO category

EXPHH	Enough information	Good behavior	Good provider	Clean facility	Less waits time
0000---3000	191 (80.3)	235 (98.7)	234 (99.6)	231 (98.3)	182 (77.1)
3001---5000	174 (77.0)	226 (99.6)	224 (99.1)	222 (99.6)	168 (74.0)
5001---7000	71 (75.5)	92 (98.9)	91 (98.9)	91 (97.8)	74 (79.6)
>7000	107 (84.3)	126 (99.2)	125 (100.0)	124 (100.0)	91 (72.8)
NGO Category					
A	155 (62.0)	247 (99.2)	246 (98.8)	248 (98.8)	190 (75.7)
B	135 (89.4)	151 (99.3)	152 (100.0)	150 (100.0)	93 (62.0)
C	253 (89.1)	281 (98.9)	276 (99.6)	270 (98.5)	232 (82.9)
By provider					
Public	92 (72.4)	123 (96.9)	123 (100.0)	123 (97.6)	75 (59.1)
Private	416 (81.3)	510 (99.6)	505 (99.2)	500 (99.2)	407 (80.3)
UFHP	26 (81.3)	32 (100.0)	32 (100.0)	32 (100.0)	26 (78.8)
Other NGO	9 (64.3)	14 (100.0)	14 (100.0)	13 (100.0)	7 (50.0)

ANNEX VII

Table VII-5: Correction ratio for adjusting sample population from census population.

Category	A		B		C		Total	
	N	Ratio	N	Ratio	N	Ratio	N	Ratio
Census								
# of Household	4500		4500		5994		14994	
# < 5 yrs	2566	0.57	2271	0.50	3651	0.61	8488	0.57
# of Elco	4426	0.98	4388	0.98	5806	0.97	14620	0.98
# of C. pregnant	281	0.06	251	0.06	478	0.08	1010	0.07
# of w. Delivered	469	0.10	456	0.10	700	0.12	1625	0.11
# of Elco con. for FP	4145	0.92	4137	0.92	5328	0.89	13610	0.91
Sample								
# of Household	951		848		1205		3004	
# < 5 yrs	1071	1.13	924	1.09	1409	1.17	3404	1.13
# of Elco	926	0.97	929	1.10	1282	1.06	3137	1.04
# of C. pregnant	161	0.17	151	0.18	280	0.23	592	0.20
# of w. Delivered	267	0.28	292	0.34	390	0.32	949	0.32
# of Elco con. for FP	765	0.80	778	0.92	1002	0.83	2545	0.85
Correction Ratio								
# of Household								
# < 5 yrs		0.51		0.46		0.52		0.50
# of Elco		1.01		0.89		0.91		0.93
# of C. pregnant		0.37		0.31		0.34		0.34
# of w. Delivered		0.37		0.29		0.36		0.34
# of Elco con. for FP		1.15		1.00		1.07		1.07

